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A STUDY OF THE EFFECTS ON THE PROVISION OF NURSING SERVICES OF DEPENDENCE ON A LEARNER NURSE WORKFORCE TO STAFF HOSPITAL WARDS

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ABSTRACT

A study of the effects on the provision of nursing services of dependence on a learner nurse workforce to staff hospital wards

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This research focuses on identifying the effects on patient care produced by dependence on a learner nurse workforce.

A framework for analysing the care given by learners was developed using a modified delphi survey. Observation took place on three training wards. Observation schedules developed from the survey were used by the nurses to identify individual aims of care for specific patients. The care given to these patients was observed and discussed with the nurses at the end of the shift.

The schedules structured the observation data. However, in collecting and analysing the data a qualitative approach was taken as it was recognised that the content of the schedules reflected a diverse range of conflicting perspectives on care. Emphasis was given to identifying how the nurses prioritised and translated the aims of care within the context of practice.

This method was developed in order to overcome the atheoretical approach to nursing adopted by quantitative methods of nurse manpower planning. These methods tend to define basic nursing care as unskilled, but fail to recognise that this may arise because this care is predominantly given by unqualified nurses.

The research demonstrates that ward staffing patterns are characterised by transience and lack of stability which arises directly from the throughput of learners. Transient nurses are responsible for implementing much of the basic care needs of patients, however very few instructions about this aspect of care were observed. When they were given they were rarely implemented. Instead basic care needs were identified by reference to the ward routine. It is suggested that qualified staff sanctioned the use of the routine as it facilitated control over standards while allowing quick and easy utilisation of transient staff on whom they depend to implement care.

PREFACE

This research study was funded by the South East Thames Regional Health Authority (SETRHA). It arose from concerns expressed by senior nurses in SETRHA about the need to identify an appropriate level for the recruitment of nurse learners in the Region. A preliminary review of the situation (SETRHA 1980) suggested that the area warranted an independent research study. The Health Services Research and Development Committee at SETRHA funded the research which was supervised by the Nursing Research Liaison Officer at the Region.

A steering committee for the research was set up by the Nursing Research Liaison Officer. The membership of this committee is given in Appendix A. This committee met regularly and provided background and contemporary information on nurse manpower planning both nationally and within SETRHA. A report, entitled "The effects on patient care of reliance on nurse learners for the provision of hospital services and its implications for manpower planning", was submitted to SETRHA on completion of the research. It formed the foundation for the development of this thesis.

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Last but by no means least I would like to thank my family, George Taylor, for his continual help and support, throughout this research, and my son Daniel who spent the first four years of his life competing with a thesis for my attention.

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LIST OF ABBREVIATIONS USED

ADNS	Assistant Director of Nursing Services
AG/EN	Agency Enrolled Nurse
AG/SN	Agency Staff Nurse
DGH	District General Hospital
DHA	District Health Authority
DHSS	Department of Health and Social Security
DNE	Director of Nurse Education
EN	Enrolled Nurse
ENB	English National Board for Nursing, Midwifery and Health Visiting
GNC	General Nursing Council
HAA	Hospital Activity Analysis
NHS	National Health Service
NR3	Nurse Ratio 3
P/N	Pupil Nurse
RCCS	Revenue Consequences of Capital Schemes
RCN	Royal College of Nursing
RGN	Registered General Nurse
RNO	Regional Nursing Officer
SETRHA	South East Thames Regional Health Authority
S/N	Staff Nurse
Sr.	Sister
ST/N	Student Nurse
UKCC	United Kingdom Central Council for Nursing Midwifery and Health Visiting
WTE	Whole Time Equivalent

Chapter One

The Emergence Of The Research Problem

INTRODUCTION

This thesis focuses upon the effects on the nursing service of dependence on a learner nurse workforce. It has its origins, therefore, in nurse manpower planning. It does not, however, adopt a conventional approach to manpower research. Instead it criticises the methods used in this field of research and attempts to develop an alternative approach, which utilizes a more qualitative, inductive framework.

The research was initiated by senior nurses working within the Regional Health Authority (RHA) that funded the research. Primarily these nurses were concerned about the practical problems of developing a system that could identify the manpower demands of the service, and the level of educational provision required to meet those demands. This chapter addresses these concerns and demonstrates how they were transformed into a decision to focus on the contribution made to patient care by student and pupil (learner) nurses.

Before describing the development of the research, some information about the professional background of the researcher is given. This identifies factors in the researchers past which influenced the direction taken in the research.

Prior to undertaking the research I worked as a ward sister on a thirty bedded mixed medical ward in a very busy Outer London District General Hospital. The ward was a nurse training ward. During my time as sister I was responsible for implementing the nursing process on the ward, and for introducing systems of patient allocation. In my attempts to understand these developments I became familiar with the social model of health, and with the idea of promoting independence in patients. I interpreted these developments as a movement towards giving patients greater control over what happens to them in hospital.

In the context of the ward in which I worked, these ideas made sense, as we frequently dealt with patients suffering from diabetes, asthma, chronic obstructive airways disease, gastric ulcers, and cerebral vascular accidents. As a result of working with these patients I became increasingly aware of the importance of involving them in the decisions taken about their care. For instance, the diet of a teenager, newly diagnosed as diabetic, had to be substantially altered once we became aware that she was very keen on playing sport. This only came to light following a re-admission, because the diet we stabilised her on in hospital, were she was sedentary, was totally inappropriate to the active life she led outside hospital. Similarly the regularised meals given in hospital did not reflect her eating habits outside hospital. Numerous other examples could be cited.

Faced with these problems and confronted with the literature

on individualised care, I also found it difficult to identify the role of the learner nurse. The patient population on this ward ranged from acute emergency admission to long-stay. Despite this I could not identify patients whose total care could be allocated to learner nurses, yet I was heavily dependent on the contribution they made to care. Neither could I completely abandon task allocation, although I could not explain the reason for this. Indeed I was assured other wards had introduced systems of patient allocation and had successfully incorporated learners into these systems.

As this chapter demonstrates the formulation of the research problem incorporated my experiences as a ward sister. Although the research originated from a very different set of problems, I found it difficult to divorce these problems from the issues with which I had been concerned as a ward sister. Because the subject of nurse manpower planning and the problems of ward organisation are merged in the research, I approach many of the issues discussed, (such as the nursing process, systems of patient allocation, nursing models, and the tension between dependency and independence in patient care,) primarily from the perspective of a practitioner in charge of their implementation. In fact, it is possible to view this thesis as an attempt to solve clinical problems, which I had experienced as a ward sister. This approach gave rise to numerous methodological difficulties which the research had to address.

ORIGINS OF THE RESEARCH

This research was initiated by the Nursing Division of a Regional Health Authority in the south of England. Discussions with nurses in this division, during the early stages of the research, revealed that they were concerned about how and in what way, nurse education could be incorporated into systems of nurse manpower planning. They wanted to develop a system that would enable them to identify the appropriate level of recruitment of learners within the Region. This raised subsidiary questions about the retention of qualified staff and the degree of self-sufficiency the Region could develop in meeting its own training needs at a Regional and District level. Conversations with the Regional nurses indicated that at a personal level they were not concerned about the issue of training more nurses than they actually needed. As they frequently pointed out, three major teaching hospitals were located within the Region, and it was generally thought that these hospitals made a national, rather than local, contribution in terms of training and research.

However, demands emanating from the Government for effective management of resources, raised questions about the Region's contribution to the national provision of qualified nurses. It focused the managers attention on ensuring adequate resourcing of existing services. The managers felt they could no longer afford to train nurses to meet national needs, but had instead to ensure that their own needs were

met. This philosophy of self-sufficiency was being transferred down to the Districts, who were engaged in a similar exercise. The problem was compounded by a lack of any adequate data on this. The managers assumed, because of the historical traditions of the teaching hospitals, that the Region did export nurses to other parts of the Country. Data to verify this was, however, unavailable.

Similar problems existed a the level of the Districts. The lack of data on the movement of qualified nurses made it difficult to ascertain the appropriate level of recruitment for learner nurses, within the Region and Districts. Consequently it was impossible to ascertain whether nurse education was under or over resourced, in terms of meeting the Regions' need for qualified staff.

These problems and concerns were very prominent in the early stages of the research, and influenced the development of the research project. The first year of the research was spent familiarising myself with the above issues, with the literature on nurse manpower planning and with the geography and organisation of the Region. During this year an extensive literature search was conducted on nurse manpower planning, and an exploratory survey of the Schools of Nursing in the Region was undertaken.

NURSE MANPOWER PLANNING WITHIN THE NATIONAL HEALTH SERVICE

Nurse manpower planning has assumed increasing importance in the National Health Service (NHS). The National Audit Office

(1985) calculated that nursing and midwifery staff represent nearly half the NHS workforce; they account for 34% of NHS revenue budget and 3% of public expenditure. Yet the Department of Health and Social Security (DHSS), in a review of methods of nurse manpower planning (DHSS 1982 & 1983), found that despite numerous research studies little progress had been made. This may result from the tendency of this research to model supply and demand in nursing as separate entities.

Studies into the Demand for Nursing Staff

Indicators of the demand for nursing staff form the basis of most studies into nurse manpower planning. Two methods for measuring demand have been developed, "top down" approaches which are usually developed at a fairly high level in the organisation, and "bottom up" approaches which usually take the form of dependency studies.

"Top-down" methods of measuring the demand for nursing care attempt to relate manpower numbers to aggregate measures of output or activity, e.g. number of beds, size of wards, bed utilisation, population density, mortality or morbidity statistics. These measurements are usually calculated for each medical speciality. "Top-down" planning is generally derived from current or past staffing levels and frequently includes measures of budget constraints. Examples of "top-down" approaches to the measurement of demand include Revenue Consequences of Capital Schemes (Ministry of Health

1965), Trent Regional Health Authority (1978), Pace and Grimshaw (1978) and the Nurse Ratio Three (NR3) formula used by the South East Thames Regional Health Authority (SETRHA) at the time of the research (SETRHA 1981, Appendix B).

"Top-down" formulae endeavour to produce standardised staffing levels across large geographic areas. Consequently they are unable to accommodate local demographic and environmental factors that might affect the demand on health care services. Neither have they been able to incorporate the level of social service or primary health care provision in a Health District. This has given rise to the development of alternative methodologies designed to produce more objective measures of demand. These usually take the form of dependency studies which attempt to both identify patients needs and allocate an appropriate number of staff with the necessary skills to meet these needs.

Dependency Studies

A large number of dependency studies have been undertaken in nurse manpower planning. These include the Aberdeen Formula (Scottish North-Eastern Hospital Board 1969), Rhys-Hearn (1977) Barr (1967) Grant (1979) Auld (1976) Senior (1979). In general, the methods adopted by these studies are derived from operational research. In most cases these studies categorise patients or nursing work into coherent groups. Workstudy techniques are used to calculate the time taken to provide care for each group of patients or each category of

nursing work. Future patients are then classified according to their patient group or the categories of nursing they require and the average amount of nursing time they need is calculated using the results of the study. The hours of nursing time required by all the patients is then totalled for the whole ward to identify the demand for nursing staff.

Studies Into the Supply of Nursing Staff

Models designed to estimate the supply of nursing staff rely almost exclusively on the use of a flow chart, which simulates the current career path in nursing, indicating points of entry and wastage to the profession. Many of the supply models also indicate the points at which nurses can move from one sector of the health service to another depending on whether they gain the necessary qualifications and experience. Examples of supply models include the DHSS (1976), Scottish Home and Health Department (1975), Howe (1981), Shipp (1980) and Horn and Naylor (1982). In most cases assumptions about the projected demand for nursing staff are derived from either "top-down" formulae or dependency studies. Estimates of wastage and re-entry rates are also built into the model. It follows therefore that the effectiveness of these models is dependent on the accuracy of these assumptions and estimates.

Matching Demand and Supply In Nursing

Demand formulae are used, therefore, to calculate the future requirements for qualified nurses within the NHS. Supply

models are used to identify the number of learners to recruit in order to meet this projected level. However during their training, learner nurses constitute up to one third of the staffing establishments of nurse training wards. Alterations in the number of learners recruited as a result of fluctuating demands for qualified staff is likely therefore, to have an effect on the flow of learners to these wards. It is possible that this may alter the demand for qualified nurses on which the model was based. It appears, therefore, that there is a dynamic relationship between supply and demand in nursing. Despite the large number of studies undertaken in the field of nurse manpower planning, this does not appear to have been explored.

It was, however, highlighted in a preliminary survey of Schools of Nursing in the Region carried out at the beginning of this research. The survey found that changes in the educational syllabus had a direct effect on the number and types of clinical areas to which learners were allocated. This in turn had an effect on a Districts' capacity to train learners. For instance, certain clinical areas such as paediatrics and obstetrics, which became compulsory following the introduction of the European Economic Community (1977) regulations, are limited in the number of learners they can actually absorb. Changes in the syllabus, which increased the number of learners requiring placement in these areas, altered the total number of learners a District could train. The supply models described

above did not appear to take this constraint into account. Instead they assumed that a District could train the exact number of nurses indicated by the projected demand for qualified staff incorporated in the model.

A description of the survey is given in Appendix C. It consisted of open-ended interviews with appropriate personnel in each school. It focused on local practices in the recruitment of learners and the retention of newly qualified nurses.

THE EXPLORATIVE SURVEY OF SCHOOLS OF NURSING

A District's capacity to train learners is determined by the number that can be seconded to the smallest specialist area in which clinical experience is required by the training regulations (DHSS 1981). These clinical areas form "bottlenecks" in the allocation process. Prior to 1977 the General Nursing Council (GNC) syllabus identified four optional areas, geriatrics, community, obstetrics, and psychiatry. Nurses only had to gain clinical experience in two of these four options. Following the introduction of the European Economic Community regulations in 1977 they had to gain the same amount of clinical experience in all four areas (European Economic Community 1977). The interviews revealed that in seven of the Districts in the Region the optional areas were also the "bottlenecks" for training. The effect of the new syllabus therefore was to reduce the number of students a District could train to the level that

could be supported by these specialist areas. Consequently there were fewer students available for secondment to staff general wards. Moreover, it was found that even if the optional areas were not "bottlenecks" within the District, time spent in these areas was time away from the general wards. This clearly reduces the number of learners available to meet the labour needs of these wards, and increases the demand for other grades of nurses.

This point was highlighted by a Director of Nurse Education interviewed during the survey. He said that he felt that, as a result of changes in the training syllabus, the contribution made by learners, to service, had fallen from 60% to 40%. When asked where he derived these numbers from? he replied that, within the overall nursing budget learners were costed as making a 60% contribution to service. The choice of this figure he felt was arbitrary, though it must have changed in the light of recent educational developments.

The survey suggested, therefore, that the contribution learners were able to make to service, and therefore the demand for other grades of nursing staff, was affected by changes in the training regulations. The above analysis suggests that the availability of learners to work on hospital wards is controlled by the educational syllabus. Changes in that syllabus will, therefore, have considerable implications for the demand for nurses at ward level. Models of supply and demand (DHSS 1983) on which strategic manpower

planning is based do not appear to take this into account; instead they assume that the demand for nursing staff is independent from the supply. The decision to focus the research on the contribution made to service by learners arose, therefore, out of deficiencies identified with traditional approaches to modelling supply and demand in nurse manpower planning. An analysis of the contribution made to service by learners appeared to provide a link between nurse education, and service, that had not previously been acknowledged by manpower planners. As a result of this early work the research started to focus upon exploring the issue of the learner nurse's contribution to service during training.

SERVICE COMMITMENT AND THE EDUCATION OF LEARNERS

Since the inception of the NHS learner nurses have worked as part of the staffing establishment of training wards, constituting approximately one third of the nurses working on these wards. There is a considerable body of research (Menzies 1967, Bendall 1974, Lelean 1973, Fretwell 1982, Orton 1981, Melia 1984), which suggests this is detrimental to their education as service commitments take precedence over learning needs.

Fretwell (1982), in a study of the ward learning environment, found that during their ward placements learners were allocated routine and basic nursing care to complete. More importantly, she found that within a few

weeks of their first ward allocation learners felt competent to provide this care with minimal supervision. Fretwell's findings reflect those of Goddard (1953) nearly 30 years earlier who had also found first year learners giving routine nursing care with little or no supervision. Similarly Reid (1985) found that the very best levels of contact between learners and qualified staff on 25 wards observed amounted to only about 1/3rd of the student nurses' time on the ward. The study indicated that on only five of the 25 wards were there more trained staff than learners.

Studies such as these suggest that although learners are allocated to the ward to gain clinical experience, the educational supervision they receive is minimal. Instead their labour provides the routine care required by patients. This has been confirmed by Roper (1976) who undertook an historical analysis of nurse training programmes in Scotland between 1940 and 1970. She found that the number of compulsory ward experiences under the training syllabus rose from 3 in 1940 to 30 in 1970, an increase of 27 ward allocations in 30 years. This increase, she suggested, was assumed to provide nurses with a better education since it prepared them for a wider range of clinical specialities. However, her research demonstrated that the work undertaken by learners in each of their allocated clinical specialities, was in fact very similar. She also found that learner nurses carried out routine basic care which varied very little from one clinical speciality to the next. Much

of this research suggests therefore, that learners are allocated to clinical specialities primarily to provide a workforce. Such a system implies that their educational needs receive only secondary consideration.

The Effects of the Educational Syllabus on Nursing Services

There is also small, but growing, evidence which suggests that the traditional training system may produce other problems which are not always recognised by the service. Melia (1984) and Menzies (1967), working from very different research perspectives, both highlight the detrimental effects on the socialisation of learner nurses produced by the transient allocations set up as a result of increases in compulsory ward experiences described by Roper (1976). Both of these studies were concerned about the development of individualised care. Menzies (1967) suggested that the temporary attachment to the ward, produced by the training syllabus, distanced the learner from the full impact of the anxieties experienced by patients and frequently projected onto the nurses, especially since the learner could be arbitrarily moved with little or no notice. Menzies suggested that as a result of such training the learner nurse tended to develop the use of avoidance as a defence mechanism against the impact of projected patient anxiety. This defence mechanism prevented the nurses from forming the individualised relationship required to help patients resolve their anxieties.

Melia (1984) found that the short allocations produced by

the training syllabus prevented the learner from becoming proficient in these areas, consequently the learner nurse is primarily in the position of a worker allocated tasks to complete, but given very little responsibility or experience in decision making. On qualifying the nurse's primary concern is with allocating work and taking decisions about care, however, they are unprepared for this role. Melia suggested that the unsettled employment patterns which are a characteristic of staff nurses reflect the coping mechanisms developed during training. The provision of numerous short courses for qualified nurses in a range of medical specialities, moreover indicates the lack of confidence felt by nurses at the end of their training.

Similarly Alaszewski (1977) in a study of nurse training in a mental handicap hospital, highlighted the detrimental effect the training syllabus had on the provision of care. He pointed out that since for many of the patients the hospital is their home, their well-being would be enhanced by a stable staffing structure which enabled constructive relationships to develop between the nurses and patients. Instead the training syllabus demanded that the nurses work on all the wards in the hospital, even though there was very little difference between the wards. Again this created considerable transience while the work on each ward was very similar. This, however, was felt to be beneficial by the qualified staff as it meant the learners could be sent to any of the wards at short notice. Collectively the above

research highlights the detrimental effects the service commitment of learners has on both their education and on the provision of patient care. It has given rise to calls for supernumerary status for nurses during training.

The Demand For supernumerary Status For Learner Nurses

The demand for supernumerary status for nurses in training has a long history. It was advocated, in various forms, by the Wood Committee (Ministry of Health 1947) and the Platt Report (RCN 1964). In 1985 both the Royal College of Nursing (RCN 1985) and the English National Board for Nursing Midwifery and Health Visiting (ENB 1985) recommended student status for learner nurses. The RCN recommends full student status for the entire three years of training, while the ENB recommends student status for the first two years. In 1986 the UKCC published a full report into the future of nurse education, Project 2000 (UKCC 1986), which it was suggested should form the basis for future developments. It recommended that there should be only one grade of learner nurse who should be supernumerary to service requirements during the first two years of training, but make a 20% contribution in the third year of training. John Moore, Secretary of State, announced the acceptance by the Government, of this proposal at the Royal College of Nursing Congress in 1988. It therefore forms the basis for future training in nursing.

The introduction of supernumerary status clearly has

implications for the organisation of care at ward level. It raises questions about the level and grade of staff that should be used to replace learners and the costs to the service of undertaking such a major change in the staffing structure of wards. Both of these issues appear relevant to a consideration of the contribution made to service by learners during training. This again, therefore, highlighted the importance of undertaking a study which focused on this issue. Particularly if, as the above literature indicated, this contribution may have detrimental consequences for patient care. An understanding of these consequences would be important in any evaluation of supernumerary status following the introduction of Project 2000 (UKCC 1986).

The decision to focus the research upon the contribution made to patient care by learners raised problems, however, as to how that contribution was to be framed and analysed. If we return to the literature on nurse manpower planning it is clear that the operational research techniques adopted in this field of research, could be used to measure that contribution in terms of learner nurse hours and the tasks they perform. Indeed a number of studies have done just that (Moores and Moult 1979, Ball, Collier and Goldstone 1984). However, in reviewing the literature on nurse manpower planning it became clear that the approaches adopted by these studies made a number of assumptions about the nature of nursing work. For instance, in order to quantify nursing work, manpower studies invariably break nursing care down

into its component parts. This produces a list of tasks that are then measured by timing. It was apparent that this produced a definition of nursing that did not accord with contemporary developments in nursing ideology and research.

Recent developments, such as the introduction of the nursing process and systems of patient allocation along with the development of nursing models, were a direct response to the over emphasis on tasks as a method of organising nursing work, which many nurses felt was detrimental to care. Studies, such as those by Lelean (1973) Menzies (1967) and Bendall (1974), all highlighted the routinised approach to care found on wards and suggested that this arose from an over dependence on task allocation. Early nursing research gave rise, therefore, to calls for a more individualised approach to nursing which identified the individual needs of patients, and met these needs within a holistic framework. It appeared, therefore, that the emphasis on measuring nursing tasks, to produce standardised timings of nursing work, found to dominate nurse manpower planning, failed to accommodate recent developments in the ideology of nursing care.

DEFINING NURSING WORK

The above analysis appeared to indicate the existence of a number of different definitions of nursing work. It therefore became necessary to analyse the definitions of nursing work incorporated in nurse manpower studies, and the definitions of nursing work implied by the introduction of

systems designed to promote individualised care in nursing practice.

Definitions Of Nursing Work Produced By Nurse Manpower Planning

One of the few manpower studies which looked specifically at the contribution to service made by learners was carried out by Moores and Moult (1979). They found that although learners, at that time, comprised only 24% of the nursing workforce they provided 75% of direct patient care. This study was interesting because it suggested that learner nurses make a disproportionate impact on the provision of patient care. Substituting other grades of staff for learners, may, therefore, fundamentally affect the care received by patients. However, despite this finding none of the studies into nurse manpower planning appear to differentiate between grades of staff; instead nurses, regardless of qualification, are seen to be interchangeable.

"Top-down" formulae which are based on aggregate figures of current staffing patterns collated at a District, regional or national level, do not acquire sufficient detail to differentiate between the contributions made to care by each grade of nurse. This does not, however, appear to be the case for dependency studies, as the use of workstudy techniques should enable the different categories of care identified to be classified according to the grade of nurse carrying it out. None of the studies appeared, however, to do this. A possible explanation lies in the empirical nature

of such studies. The role definition of nursing developed in these studies is derived from practice as it is observed by the researchers. There is substantial evidence which indicates very little differentiation between the work undertaken by different grades of nursing staff at ward level, particularly in relation to direct patient care, which is the focus of most of these studies. For instance, Hardie (1978), in an investigation of auxiliary nurse training courses, found "that all the task areas covered in the registered nurse syllabus of the General Nursing Council, with the exception of injections and certain forms of drainage, are carried out somewhere in the UK by auxiliaries" (Hardie 1978 p.47).

Moores and Guinnett (1982), in a study of 350 learners in 10 different hospitals, found that 32% of third year student nurses said, in response to a questionnaire, that they were "quite often/very frequently" left in charge of a ward during day shifts, and 29% of first year learners said they were "quite often/very frequently" left in sole charge of a ward on night duty.

Similarly, the distinction between the staff nurse and the enrolled nurse has never been clearly defined. The enrolled nurse was originally envisaged as an "assistant" to the registered nurse (RCN 1943). However, in 1977 the GNC commented in the educational syllabus of that year, "Until there is much more clarity concerning the respective roles

of registered and enrolled nurses there is a continuing reluctance to define specific training outcomes for the two levels of training" (GNC 1977 p.4).

Therefore, although Moores and Moult (1979) found that learners carried out a disproportionate amount of basic nursing care, they were not the only grade to contribute at this level. Nursing appears singularly unable to identify the skills necessary to carry out different aspects of care. The only distinction that is commonly made in the studies discussed above is that between basic nursing care, technical nursing care and administration or management of the ward. This classification was first developed by Goddard (1953). Basic care refers to the more personalised nursing such as bathing or mobilising a patient. Technical care refers to curative interventions undertaken by nursing staff, such as care of intravenous infusions. Administrative work includes such things as the organisation of admissions and discharges to the ward.

The development and continued use of these three categories of nursing work reflects the predominant organisation and allocation of nursing work since Goddards study. As Hegyvary (1982) points out during the 1950's and 1960's scientific management techniques derived from industry were increasingly used in nursing to promote an efficient and rational use of resources. These techniques resulted in the increasing use of task allocation as a means of organising nursing work. Under task allocation patient care is divided

into tasks of increasing complexity. Basic care is seen to require the least amount of skill and is allocated to nurses with the least training. Technical care requires more skill and is allocated to nurses with more training, whilst administration is seen to require the most skill and is allocated to the most senior nurse on duty. The actual grade is dependent on the mix of grades on duty at the time. Hence an enrolled nurse can be in charge of the ward one day and yet be the most junior nurse on duty the next day with only basic work to complete.

Definitions of Basic Nursing Care Produced By Manpower Planning

It follows, therefore, that current approaches to 'demand' planning in nursing, whether "top-down" or dependency studies, serve only to reinforce the prevailing hierarchy in skill definition, as this is what is captured in the empirical methods used in the development of these formulae. The emphasis on empirical method to the detriment of theory development has resulted in a failure to question whether the mix of skills observed on the ward is the most appropriate for meeting the needs of patients; instead the definition of basic care as unskilled is assumed to be accurate because it reflects contemporary practice. This criticism is substantiated by Waite and Hirsh (1985) who used the professional judgement of ward sisters as a method for determining staffing levels and compared this with measures of demand produced by dependency studies. Their

findings indicate "that sisters' judgements of required nurse numbers compare very well with those produced by the best dependency methods" (Waite and Hirsh 1985 p.24). This finding appears to suggest that far from producing objective indicators of the demand for nursing care, the complex formulae produced by operational research serve only to quantify nursing work as it has become defined by historical patterns of nurse staffing.

Definitions of Basic Nursing Care Found in Nursing Research

The hierarchy in the complexity of nursing work indicated by Goddard (1953) seems to be widely accepted by the profession. For instance Menzies (1967) Fretwell (1982) and Reid (1985) all appear to adopt it as a framework for analysing the findings of their research. Menzies suggests "The nursing service must face the dilemma that, while a strong sense of responsibility and discipline are felt to be necessary for the welfare of patients, a considerable proportion of actual nursing tasks are extremely simple" (Menzies 1967 p.21). Similarly, Fretwell (1982) suggests that greater learning opportunities exist when learners are involved in technical care, since this has a decision making component not found in basic routine care, which, she suggests, enhances learning opportunities.

Reid's study (1985) also defined basic care as low level unskilled work. She developed learning objectives for each year of student nurse training. For first year student nurses these were:- bed bathing a patient; taking and

recording temperature pulse and respiration; giving a verbal report. For second year student nurses they were:- administration of medicines to four patients; testing the urine of a diabetic patient; admission of a patient to the ward. For third year student nurses they were:- taking charge of the ward; producing a written report; demonstrating good communications with staff and patients on the ward. The criteria for first year nurses appears to reflect basic care, for second year nurses technical care, and for third year nurses the development of supervisory skills which would prepare them for the role of staff nurse, able to manage the implementation of care by others, rather than be responsible for implementing it themselves.

In all these studies basic care is seen as low level unskilled work requiring only minimal training. It compensates for the patient's loss of physical functioning following the onset of disease until such time as the disease has been cured by medical intervention. Frequently it is indistinguishable from the care given by lay carers at home, and therefore, in the absence of lay carers, it can be allocated to untrained auxiliary and junior learner nurses.

Consequently, basic nursing care is often regarded as work which can be undertaken by a kind caring person with some degree of common sense, but who requires little or no formal training. Within this conceptualisation, little or no inherent therapeutic value is attached to its performance.

This suggestion is borne out by Coveney (1983), a nursing auxiliary, who describes how, on her third day on the ward, on the basis of no training, she was told to wash a patient unsupervised. The patient, she later discovered had had an Abdomino-Perineal Resection the previous day. She describes how terrified she was by all the drips and tubes attached to the patient. The instruction had apparently been given by the ward sister, presumably on the basis that washing a patient is a low level task requiring no skill or training.

The suggestion that basic nursing care contains no inherent therapeutic value, and therefore requires little knowledge or training, is however increasingly being challenged. Considerable research into areas such as nutrition (Jones 1975, Hamilton-Smith 1972), communication (Macleod-Clark and Bridge 1981, Faulkener 1984, Bond 1978) urinary and faecal incontinence (Norton 1986), constipation (Wright 1974), pain control (Hayward 1975), and prevention of pressure sores (Norton et.al. 1975, David et.al. 1983), all highlight the contribution basic nursing care makes to both the rate and extent of patient recovery.

For instance, Jones (1975) demonstrated that the content and administration of tube feeds for unconscious patients was allocated to learner nurses. From the instructions given to these nurses it was impossible to determine what the qualified staff considered to be an optimal diet and fluid intake for these patients. However when their intake was compared to DHSS guidelines it was frequently found to be

inadequate.

Chapman and Chapman (1986) highlight the importance of an adequate nutritional intake to promote tissue healing. They refer to the work of Evans and Stock (1971), and Davies and Snaith (1980), who both demonstrated that elderly patients are vulnerable to developing subclinical malnutrition while in hospital. Yet it is precisely these patients, the elderly and the immobilised, who were found by David et.al. (1983) to experience the highest incidence of pressure sore development.

The study by David and her colleagues also indicated that 24% of the patients in their sample had experienced urinary contamination of their pressure sore and 31% had experienced faecal contamination of the sore. Considerable research has been undertaken into the management and control of urinary and faecal incontinence. Norton (1986) suggests that if current knowledge about incontinence was applied in practice the incidence could be dramatically reduced. Yet, as she indicates, two studies Reid (1974) and Ramsbottom (1980) both indicated that care of incontinence is allocated to junior staff, primarily auxiliaries. There is frequently no accepted procedure and these nurses did not seek advice as they were supposed to know how to cope.

The above analysis of definitions of nursing work produced from nursing research is interesting because it indicates that studies which are based on direct observations of

practice, such as those by Menzies (1967), Fretwell (1982) and Reid (1985), tend also to define basic nursing care as unskilled. In contrast, research into aspects of clinical practice, such as the studies by Norton et.al. (1975), David et.al. (1983), Norton (1986), Faulkener (1974) and Bond (1978) indicate that aspects of basic nursing care e.g. care of pressure areas, urinary and faecal incontinence and communication, all in fact require nurses to possess a high level of skill, if the findings are to be implemented. Frequently however, this care is allocated to untrained staff without proper instruction who are then left to cope. It is assumed that tasks such as bathing or mobilising a patient require little training or expertise and that such care is essentially ameliorative until cure can be achieved by technical intervention.

Definitions of Nursing Produced by the Medical Model

In accepting and defining basic care as unskilled, nursing has, in effect, accepted the definition of health and illness developed by medical science. Osherson and AmaraSingham (1981) suggest that medicine has increasingly conceptualised the body as a machine made up of component parts which can be examined and treated in isolation from one another and from the rest of the body. Similarly Seedhouse (1986) suggests that medicine assumes the best way to cure disease is to reduce bodies to their constituent parts and treat the diseased part rather than the ill person.

Both Seedhouse (1986) and Osherson and AmaraSingham (1981) suggest that the domination of medical science by the machine metaphor gives rise to the view that health is a commodity that can be supplied by the application of appropriate technical interventions following the onset of disease. Seedhouse further suggests that while this definition of health has been criticised as narrow and mechanistic by social scientists, they to have failed to accommodate a broader definition of health in their own analysis. Instead social scientists also define health as a commodity that can be acquired through access to curative facilities.

Within this conceptualisation of health and illness, health is defined as the absence of disease. Health, for an ill person, can only be achieved by curing the underlying disease process. By adopting a medical definition of health and illness, nursing has come to attach more status to, and assume more skill is required for, the completion of the technical tasks associated with curing disease. This is seen as the primary means by which a patients dependency on nursing staff is reduced. Caring for the physical needs of the patient which result from the disease process, is regarded as secondary and ameliorative until cure can be effected. As a result, White (1985) suggests that basic nursing care has been consistently undervalued in the health service. This has prevented the emergence of a clinical structure in nursing. Consequently nursing has never

achieved the autonomy which characterises classical definitions of professional work.

Definitions of Nursing Produced by Social Models of Health

As long ago as 1966 Henderson (1966) suggested that:-

> "The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible. This aspect of her work, this part of her function, she initiates and controls; of this she is master" (Henderson 1966 p.15).

The development of this definition of the function of the nurse by Henderson can be seen as a synthesis of ideas developing in disciplines such as philosophy, psychology and sociology, which are increasingly being applied to health care. The incorporation of concepts such as independence reflects an expansion in the definition of health care beyond definitions derived from a purely medical or physiological definition of health as depicted in the mechanistic model of medical science described above.

Bower and Bevis (1979) draw on the work of Dunn (1961) to develop a philosophical definition of health which they consider more appropriate as a guide to nursing action than the medical model. Dunn (1961) defined wellness as a progressive growth towards the fulfilment of an individuals potential. Following this definition Bower and Bevis develop a dynamic circular rather than linear model of health and illness. In this model, emphasis is placed on the direction in which a person is heading rather than on their current

position. They suggest therefore that "for health purposes then, the individual must be treated, not as a group of parts, but as an integrated whole, living and interacting with the environment, with the entire super-system in ecological balance and progressing towards wellness" (Bower and Bevis 1979 p.8).

Patterson and Zderad (1976), in a discussion of the humanistic foundations of nursing, suggest "For the process of nursing to be truly humanistic it must bear out, that is, be a lived expression of, the nurse's recognition and valuing of nursing as an opportunity for the development of the human person" (Patterson and Zderad 1976 p.15-16). The incorporation into nursing theory of concepts such as independence, fulfilment of human potential and human development are derived from concepts of 'wellness' (Dunn 1961) and 'self actualisation' (Maslow 1968), which challenge the traditional definition of disease and illness produced by medicine. As described above medicine defines disease as a breakdown of physiological functioning which has to be identified, isolated and repaired for health to be restored. The wellness model presents a broader definition of disease. It recognises environmental and behavioural causes of disease as well as recognising that feelings about self and self esteem can give rise to illness and disease. For example, a person who possesses full physical fitness may require health care intervention because their living environment, behaviour, or feelings about self, are likely

to result in disease, either physical or psychological.

The development of the social model of health and its adoption by nursing in the form of nursing models (Henderson 1966, Roper Logan and Tierney 1980, Bower and Bevis 1979), has accompanied the introduction of the nursing process and systems of patient allocation. Increasingly emphasis is placed on identifying and meeting the individual needs of patients, within a framework which focuses on promoting their independence. Reliance on task allocation is seen as detrimental to this process as it subjects the patient to the ward routine, and therefore, it is suggested ignores their individual needs for care. The introduction of individualised care raises questions about whether the work performed by nurses using a task orientated approach is appropriate or meaningful to meeting the needs of patients. It is at this point that assumptions about nursing work inherent in traditional approaches to nurse manpower planning, diverge from contemporary developments in nursing ideology.

In focusing on developing methods to measure what nurses do, nurse manpower planners have failed to consider whether the tasks that they time, are appropriate or necessary, to meeting the needs of the patient. Instead they have assumed that nursing practice, by definition, meets patients' needs. An assumption that has been subjected to extensive criticism by nurse researchers. As the work of Jones (1975), Hamilton-

Smith (1972), Macleod Clark and bridge (1981), Faulkener (1984), Bond (1978), Norton (1986), Norton et.al. (1975) and David (1983) discussed earlier, illustrate, much of the care given by nurses is inappropriate and may even be detrimental to the patient's recovery. Moreover, much of this research focuses on care that has traditionally been described as basic care and implemented by unqualified nurses.

This appears to suggest that the definition of basic care as unskilled, assumed by nurse manpower research, could in fact be tautological. This definition is derived from the dependence on empirical method, which produces formulae which reflect contemporary practice. The problem is that the unskilled definition of basic care produced by this method, may arise from the fact that this care is primarily implemented by unqualified staff. This point appears to be central to a discussion of the contribution made to care by learners, because, by definition, learners are not yet qualified. This criticism of manpower research highlighted the need to analyse the contribution made to practice by learner nurses, within a framework which incorporated the concept of individualised care, and so reflected contemporary developments in nursing knowledge and ideology.

PROFESSIONALISM AS A STRATEGY FOR CHANGING PRACTICE

The research into basic nursing care cited above, along with the development of nursing models which reflect social as against bio-medical definitions of health and illness, highlights the contribution that specialised knowledge could

make to improvements in nursing care. The introduction of the nursing process (GNC 1977), systems of patient allocation, individualised nursing care, and the development of nursing models all reflect attempts to change the quality of care given at ward level. In attempting to change practice, however, nursing has also been adopting a strategy of professionalisation.

Turner (1987) suggests that in a highly differentiated society certain groups will develop the specialised skills and knowledge associated with the service needs of society, and at the same time will acquire control over practice in order to ensure quality provision. Recent developments in research are providing nursing with the specialised knowledge associated with professional practice. In attempting to develop and control this information, nursing can be seen to be adopting a strategy of professionalisation.

In nursing, basic care has been singled out as an appropriate area in which to develop the expertise of nurses (MacGuire 1980, McFarlane 1980, Roper Logan and Tierney 1980). Dickinson (1982), in a review of the available areas of knowledge in which nursing could develop expertise, suggests that an appropriate professionalising strategy for nurses involves a redefinition of basic care as a "problem-orientated, patient centred activity requiring considerable expertise and scientific knowledge. It thus provides for

qualified nurses a means of recovering the only territory they can claim as their own" (Dickinson 1982 p.62).

Increasingly, therefore, basic nursing care is being highlighted as the area which can be used to demarcate the contribution made by nurses to patient care, from the contribution made by other health care professionals, in particular doctors. Attempts to delineate an area of specialised knowledge and claim it for nursing reflect a desire to acquire the traits which characterise an occupation as a profession. The trait theory of professionalisation has been the subject of much criticism, Johnson (1972), for instance, highlights the atheoretical and therefore arbitrary and normative nature of the lists of traits produced. Schrock (1987), Strong (1979) and Davies (1983) point out, that the professions which gain power within a society, tend to reflect the particular economic and social organisation of that society. Dingwall (1983) and Schrock (1987) suggest, the central question confronting society in relation to professional power is the extent to which "expertise can be controlled in any society so that it does not become privileged and institutionalised and supportive of a system of dominance" (Schrock 1987 p.19). It is clear from this question that of all the traits identified as conferring professional status, the one that remains unresolved in the field of professional practice is the nature of professional knowledge.

The importance of the knowledge base to an understanding of

professional work, is derived from attempts to explain the specialised differentiation of labour which characterises complex societies. Turner (1987) has suggested that in the classical sociology of Durkhiem the professions represent the institutionalisation of altruistic values in which their contribution is differentiated by their commitment to various forms of personal service and community welfare. This perspective emphasised the ethical character of professional work, its service to persons, and its basis in technical knowledge.

Johnson (1972), however, extends the analysis of specialisation beyond the creation of interdependence which underpins the above analysis, highlighting instead the potential for professional autonomy and control. He suggests that it is social distance as a product of the division of labour, which creates the potential for autonomy. "Social distance creates a structure of uncertainty, or what has been referred to as indeterminancy in the relationship between producer and consumer, so creating a tension in the relationship that must be resolved. There is an irreducible but variable minimum of uncertainty in any consumer-producer relationship, and depending on the degree of this indeterminancy and the social structural context, various institutions will arise to reduce uncertainty. Power relationships will determine whether uncertainty is reduced at the expense of producer or consumer" (Johnson 1972 p.41).

Johnson further suggests that as a result of professional autonomy, professions within society are able to secure a monopoly position over their field of expertise. They control both the interpretation and use of knowledge in their field, while at the same time demanding high status rewards. They are impervious to challenge by consumers or administrators, who lack the technical expertise necessary to criticise or judge performance. This power Johnson suggests, enables professionals to increase social distance and their own autonomy and control over practice by engaging in a process of 'mystification'. "Uncertainty is not, therefore, entirely cognitive in origin but may be deliberately increased to serve manipulative or managerial ends" (Johnson 1972 p.43).

It is against this background, and confronted with the tension between altruistic service and professional domination that nursing is attempting to acquire professional status. Demands for professional status emphasise the importance of developing a scientific research base as a foundation for clinical practice. This clearly conforms to traditional definitions of professionalisation, as it represents an attempt to develop a unique knowledge base which is controlled by the profession. However, the introduction of the social model of health to nursing, as a basis for professionalisation, is more problematic. While most of the literature on individualised care appears to support the promotion of independence for the patient, as a

primary aim of nursing care, there appears to be little or no consensus as to what constitutes independence for a given patient, or any agreement about how this can be achieved in practice.

DEVELOPING INDIVIDUALISED CARE IN NURSING PRACTICE

Seedhouse (1986) for instance, suggests that the social model of health contains inherent contradictions. The achievement of complete mental and physical well-being for one person may only be achieved by denying or undermining another persons development. Policies designed to promote the independence of the elderly or of physically or mentally handicapped people by caring for them in the community, may constrain their relatives from achieving fulfilment in other aspects of their lives, if instead they have to stay home and care for these people.

This problem is found in the work of Bower and Bevis (1979). They dismiss the mechanistic model of health produced by medicine, which they suggest results from an overwhelming dependence on empirical positivism. Instead, Bower and Bevis advocate the adoption of a holistic framework for the practice of nursing. They suggest that nursing is a process in which the nurse acts to help people maintain an "optimal" level of functioning within society. The notion of optimal functioning, however, does not necessarily incorporate a striving towards the fulfilment of human potential, rather it suggests an adaptive balance between the individual and the environment, incorporating the concept of balance or

homoeostasis. An optimal level of adaptive functioning could in fact be defined as the individual accepting the illness and the illness environment, as suggested by Parsons (1951) in his definition of the sick role. Learned helplessness, or patient dependency on medical and nursing staff, could be defined as an optimal adaptive response to current health care structures and the mechanistic definition of health produced by medical science. As Seedhouse (1986) points out, the problem of what is a successful adaptive response to illness has never been clearly defined. Moreover the social or wellness model of health does not have a monopoly over the concept of independence. Indeed it is possible to identify this the ultimate goal of medicine. It is, however, possible to distinguish a key difference in the definition of independence used in the social model, as against the medical model.

This difference focuses on whether this goal is seen as extrinsic to the healing process and therefore the end product of care, i.e. only achievable once the disease process has been cured, or whether it is seen as intrinsic to the actual process of healing.

An extrinsic definition of autonomy/independence in health care is derived from the medical model. It suggests that experts use technical knowledge to cure the disease process; once cured the patient then becomes independent from the health care workers. This description of the relationship

between professionals and clients reflects the traditional conceptualisation of professional work developed in classical sociology. Here the patient's decisions are necessarily temporarily subordinated to those of the health care workers, precisely because the patient lacks the knowledge to take informed decisions, and therefore act autonomously in relation to their own health care needs.

Conversely, the social or wellness model suggests that patient autonomy/independence is a necessary or intrinsic part of the healing process. Seedhouse (1986), in an attempt to operationalise the concept of the wellness model of health, suggests that work for health is essentially enabling: "It is a question of providing the appropriate foundations to enable the achievement of personal potentials. Health in its different degrees is created by removing obstacles and by providing the basic means by which biological and chosen goals can be achieved" (Seedhouse 1986 p.61). This formulation of the wellness model of health by Seedhouse challenges many of the assumptions that underpin the medical model of practice. The idea of allowing patients to choose their own goals recognises that the goal of complete mental and physical health, which is implicit in medicine, is unrealistic. It acknowledges the difficulties which surround actually defining what we mean by health, and the limitations of the medical definition of health as the absence of disease processes which can be diagnosed. It recognises instead, that it is possible to talk about a

person having fair or even good health in the presence of obstacles such as disease, injury, handicap or illness. It therefore recognises the need for health care workers to promote the potential in these patients, which implies the growth of autonomy and independence, even though they are not cured.

As Seedhouse points out, the difficulty confronting efforts to apply the wellness model of health in health care revolve around attempts to define what is meant by the achievement of full potential, independence, or autonomy. Bower and Bevis (1979) for instance, not only endeavour to define an optimal level of functioning for individuals, but go on to suggest that the role of the health worker is to bring about adaptive change in the individual, so that optimal functioning is achieved. Like the definition of the role of the nurse by Henderson (1966) given above, this seems to suggest that the health worker, as a result of their knowledge, is better able to determine the goals of care than the patient. This approach to the wellness model appears merely, therefore, to remove the patient from the domination of medical patriarchy and replace it with the domination of a nursing matriarchy. As Seedhouse points out, the work of health workers should be confined to the removal of obstacles which prevent the realisation of potential. In the last analysis it is up to the individual whether or not they choose to realise their potential, and the direction they take in doing this.

The introduction of the social model of health to nursing can therefore be seen to be problematic because it identifies the promotion of independence as an intrinsic aspect of nursing care. Clearly its introduction puts the patient at the centre of the decision making arena about their care. In so doing it therefore promotes individualised care. However such a focus does not fit easily into traditional models of professionalism which are premised on the need for the professional to take decisions about care, as it is they who possess the expert knowledge. From a practice perspective the social model of health also creates problems, as the shift in control over the decision making process, from professional to patient, advocated by adherents to this model, conflicts with contemporary custom and practice which are based on traditional formulations of professionalisation depicted by the medical model.

The discussion of the social or wellness model of health given above highlights the difficulties nurse practitioners may face when attempting to incorporate this model into nursing practice in an environment still dominated by the medical science. Fig. 1 was developed by Miller (1985) in a discussion of the relationship between nursing theory and nursing practice. As Miller recognises, the statements given represent crude generalisations which cannot be applied to all nurse practitioners nor to all nurse theorists. What they do represent is two separate and in many ways conflicting definitions of nursing practice, which derive

Fig. ONE

Areas of divergence between practitioners and educationalist/theorist

	Practitioners	Educationalist/Theorist
Background and education	A trained nurse working within a massive bureaucracy	A trained and/or educated professional usually employed in an educational establishment.
Employment situation	One of a group of nurses caring for a group of patients within an imperfect and intransigent system	One nurse writing or teaching about ideal care in a hypothetical situation
Relationship to reality	One who tends the cogs of reality	One who shapes reality according to a stated purpose
Perception of nursing	Nursing is what nurses do - nursing is what is	Nursing is what nurses ought to do - nursing is what nursing should be
Perception of patients	Often fragmented and partial view of patients e.g. the 15 year old appendectomy in bed 6	Often an overwhelmingly comprehensive view of patients, e.g. bio-psychosocial being
	Patients tend to be given role identity	Patients' personal identity emphasized
	Patients seen as more or less passive recipients of care	Patients seen as active participants in care
	Patients treated alike: nurses must not show favouritism	Patients are unique and must be treated differently
Perception of health and illness	Health of marginal importance in a national sickness service	Health of central importance
	Health education little practised	Health education a primary concern
	Nurses care for people who are unable to care for for themselves	Nurses not only care people they educate them to accept responsibility for their health
Nursing knowledge	Nursing mainly seen as 'doing'-skills very important	Nursing mainly seen as 'knowing'-knowledge very important
	Nursing interventions of central importance	Nursing interventions only part of nursing
Emphasis on	Concrete and particular knowledge	Abstract and general knowledge
	The content and method of nursing	The principles underlying nursing
Valued knowledge	Knowledge based on experience and tradition most valued	Knowledge based on research most valued
	Immediately useful background knowledge and knowledge about patterns of action valued	Enlargement of body of nursing knowledge valued
Knowledge transmission	A fund of practical wisdom passed on by word of mouth, by procedures and by 'sitting next to Nelly'	A body of theoretical knowledge passed on by writing, by teaching and by advocating a rational planned approach to nursing care

Taken from:- Miller A. (1985) The relationship between nursing theory and nursing practice. Journal of Advanced Nursing, 10, 417-424.

from two quite distinct ideological premises in health care; the medical definition of health and illness and the social definition of health.

Robinson (1987) also addresses the question of the division between theory and practice in nursing. She distinguishes between knowledge derived from technological research, and knowledge derived from what she describes as enlightenment research. Robinson locates the problem confronting nursing in the use of the technological model of research as a basis for generating knowledge. She recognises that this approach encourages the researcher to collect empirical data for the purpose of solving well formulated problems. However, as Robinson (1987) suggests, inherent in this approach is the assumption that the problem can be clearly defined, that everyone will agree with the the formulation of the problem, and that the desired end state can be identified. As Robinson points out, an analysis of these three assumptions is crucial to an understanding of the problems confronting practitioners in the application of knowledge derived from technological research.

By contrast, Robinson (1987) discusses the enlightenment model of research which is derived from social research. The aim of enlightenment research, she suggests is not to provide answers, which pre-supposes that contexts can be fixed, variables controlled and law-like solutions applied, but to clarify and deepen our understanding so as to improve our capacity for judgement and the use of intuition in

practice.

This clearly relates closely to the work of Schon (1983). Schon, in a critique of technical rationality suggests that individual practitioners develop certain ways of framing problems, this will shape their practice by determining the strategies they select to change or resolve the problem. If practitioners are unaware of the frames they are using then they do not experience the need to choose between frames. Reality is not constructed, it is taken for granted. If, on the other hand, the practitioner becomes aware of the frames in use, then they also become aware of how these shape reality, and of alternative ways of framing the reality of practice.

Fig 1 developed by Miller (1985), in many ways reflects the development of two alternative perspectives or frames which can be used to shape nursing practice. The adoption of either perspective will determine how problematic situations are framed and analysed in nursing practice. However, as Robinson goes onto point out, it is the practitioner, and in particular the ward sister, who must at all times keep an appropriate balance between the knowledge derived from differing and in many respects contradictory perspectives. As Robinson suggests in discussing the application of research, "insufficient recognition has been given historically to the demands which are made on her (the ward sister) in trying to understand, and reconcile the competing

life worlds of those with whom she is involved" (Robinson 1987 p.425). Individualised care requires nurses to develop the autonomy necessary to reconcile the competing frames in the interest of the patient. This may differ for patients with a similar medical diagnosis according to their life circumstances. However the domination by medical science, and the de-valuing of nursing practice this implies, may prevent the development of this autonomy. This is particularly true if one considers literature on the role of the learner nurse following the introduction of social definitions of health to nursing practice.

The Learner Nurses' Role in Individualised Care

The rejection of the narrow definition of health produced by the medical model, and attempts by nursing to promote a broader definition which incorporates the social model, underpins the introduction of individualised care, the nursing process, and systems of patient allocation. However, implicit in the literature on the nursing process, is the suggestion that these changes can be introduced without a change in the staffing structure on the ward.

Systems of patient allocation were introduced in nursing to overcome problems associated with task allocation. Under task allocation, nursing work was divided up into a series of tasks of increasing technical complexity. These were allocated to nurses according to their level of seniority. Each nurse was responsible for implementing the allocated tasks to the appropriate patient. This, it was suggested

(Duberley 1979, Hunt and Marks-Maran 1980), created fragmented routinised care in with no one person was responsible for identifying needs which arose outside the routine, and accountable for ensuring these needs were met.

The introduction of systems of patient allocation, in which an individual nurse is expected to implement the total care of one of more patients for a specified period of time, was designed to overcome these problems and so promote a more individualised approach to care. However, in advocating the introduction of patient allocation, the problem of dependence on a learner nurse workforce, and the effects of this on the staffing structure of the ward does not appear to have been addressed.

In discussing systems of patient allocation, Duberley (1979) highlights the need to match the skills of the nurse to the care required by the patient(s) to whom she is allocated. However there appears to be very few guidelines on how this can be achieved, given that most nurse training wards will be composed of a mixture of qualified and unqualified staff. Duberley comments "It is not sufficient to assume the less ill or less dependent patient may be cared for by junior nurses" (Duberley 1979 p.106), as these patients may require preparation for discharge which demands teaching skills not yet acquired by these nurses. Conversely, Matthews (1982) suggests convalescent and ambulant patients can be allocated to the care of auxiliaries.

Despite this problem both Duberley (1979) and Matthews (1982) suggest that the nursing process can be introduced on wards dependent on unqualified staff. They suggest the problem is overcome if qualified nurses identify the individual needs of patients in the care plan. The implementation of care can be delegated to learners and auxiliaries, who by adhering to the care plan, implement individualised care, without the need to take any decisions about that care. This analysis of the role of the learner nurse following the introduction of the nursing process maintains the traditional distinction between the management role of qualified nurses and the worker role of learners. It therefore assumes that, providing decisions about care are taken by qualified staff, the actual implementation of care can be undertaken by unqualified staff. This appears to maintain the unskilled definition of nursing practice associated with the medical model of care.

In contrast, Pembrey (1980), Fretwell (1982), Orton (1981), Ogier (1982), Hargreaves (1979), Hunt and Marks-Maran (1980) and Barnett (1982) all recognise that changes in nursing designed to introduce social definitions of health into nursing practice, require that learners become more involved in making decisions about patient care. Pembrey (1980), for instance, suggested that the routinised approaches to patient care associated with task allocation resulted from dependence on a hierarchical management structure, which gave rise to mechanistic forms of work organisation. The

introduction of individualised care, she argued, required a change in work organisation towards a more organic form of management coupled with a system of patient allocation. Under organic management the sister sets the work boundaries through the care plan. She allocates nurses to patients. The nurses implementing the planned care work autonomously and are able to negotiate the implementation with the patient. Thus decision making is devolved to the point of action. This, Pembrey argued, produced a more professional orientation to nursing work. Pembrey's findings are supported by Fretwell (1982) Orton (1981) by Ogier (1982).

Hargreaves (1979), Hunt and Marks-Maran (1980) and the work of Barnett (1982), all suggest that the introduction of individualised patient care improves the education of learners during clinical experience. For instance, Hunt and Marks-Maran suggest that by including learners in the planning and decision making aspects of patient care, the level of supervision they receive increases; this is bought about by an expansion of the staff nurses role. The staff nurse moves from a position of manager allocating tasks to junior staff, to a practitioner supervising the less experienced.

However, although as Pembrey (1980) suggests, the introduction of organic, democratic ward management to nursing connotes a more professional orientation to practice, it also appears to reinforce a definition of nursing as unskilled work that can be allocated to

unqualified staff, and therefore it serves to blur still further the distinction between qualified and unqualified nurses. Under task allocation the role of unqualified nurses was limited to implementing instructions. Advocates of organic, democratic management, however, have failed to clarify the types of decisions that can be devolved to learners if they are to implement individualised care. Similarly, accountability for the consequences of decision making about care, by learners has rarely been considered. Far from promoting professional practice, the devolution of decision making to learners would appear to reinforce the definition of nursing care as unskilled, by suggesting that no specialised knowledge is in fact required to carry out any aspect of patient care.

This problem is compounded by the need to maintain continuity of care. The introduction of systems of patient allocation as part of the process for promoting individualised care, emphasise the importance of establishing a one to one (or one to team) relationship between a patient and the nurse(s) allocated to care for them. This is seen to be necessary in order to ensure the individual needs of the patient are known to, and met by, the nurses. However, given the confusion that currently surrounds the role of the learner nurse in the literature on systems of patient allocation, described above, it is not at all clear whether learners possess the skills necessary to be allocated consistently to one set of patients, and to

implement all their care needs throughout the duration of their admission.

It appears therefore, that the role of unqualified staff following the introduction of individualised care, has yet to be clarified. Schon's (1983) work emphasises the importance of skilled judgement in professional work. He suggests that practitioners who recognise multiple ways of framing problems are more likely to produce solutions that fit the specific and individual needs of clients, than practitioners who use only one framework for practice.

The earlier discussion of the introduction of nursing models designed to promote patient independence, and give patients greater control over the decision making process, implied that nursing problems could be framed by a number of different, and sometimes competing, perspectives. This raises the question as to whether the nurses, who actually implement care, need the ability to recognise and choose between frames, in which case Schon's work suggests they need to be trained. Or whether this can remain the prerogative of qualified staff, who identify the appropriate framework for care in the care plan, but delegate the implementation of that care to unqualified staff.

THE DEVELOPMENT OF THE RESEARCH PROPOSAL

The above discussion suggests that definitions of basic nursing care as unskilled are derived, in part, from the

application of the medical model to definitions of nursing practice. Attempts by nursing to develop a more individualised approach to nursing care are derived from research which highlights the skilled nature of basic nursing care to patient well-being. The promotion of individualised care can also be seen in the introduction of the nursing process, systems of patient allocation, and nursing models, all of which reflect attempts by nursing to improve the standard of basic nursing care, by matching the care given to the individual needs of patients. However, the issue of the role of unqualified staff within this definition of professional practice has never been established.

As discussed above, manpower studies designed to determine the demand for nursing staff at ward level tend to embrace medical definitions of basic nursing care as unskilled. Therefore, they reinforce existing staffing structures which could well perpetuate current problems. Consequently it is possible to argue that these formulae do not produce objective indicators of demand, instead they produce numerical descriptions of practice which reflect historical staffing patterns. Included in these historical patterns is the provision of care by nurse learners who, along with auxiliaries, focus primarily on meeting what Goddard (1953) first described as the basic care needs of patients. That this definition of basic care as unskilled could arise from the fact that it is implemented by unqualified staff, does

not appear to have been investigated.

The Aims Of The Research

As a result of the above analysis the following aims for the research were developed:-

1.To examine the contribution made to patient care by learner nurses.

2.To describe the effects on the organisation of nursing produced by dependence on a learner nurse workforce.

Methodological Issues Which Arise From The Above Aims

A number of methodological issues arose out of the development of the above aims. These issues are introduced in this section. Their resolution in this research, is described in Chapter Two. In developing the above aims it was recognised that an analysis of the contribution made to patient care raised problems as to how that contribution was to be framed and analysed. It was clear that traditional manpower methodologies were inappropriate as they focused on what nurses do, rather than whether what they do is appropriate or meaningful for the patient. This suggested the need to develop a framework for analysing the contribution made to patient care by learners which reflected contemporary developments in nursing knowledge and ideology. The work of Robinson (1987), Miller (1985) and Schon (1983) highlighted the need for this framework to reflect the problematic nature of the concept of individualised care which incorporated the multiple definitions of independence found in the literature.

Secondly it was necessary to address the issue of the organisation of care on the ward, and to identify how work was allocated to learner nurses. This raised the issue of the degree of continuity of care achieved on wards which are dependent on learner nurses.

Thirdly, given the problematic and competing definitions of nursing, described in this chapter, it was important that any framework produced to analyse the contribution of learners, was not imposed onto the nurses. Instead it was recognised that the framework was itself likely to contain constructs about nursing which may be difficult to implement in practice. Therefore, at no point must the framework be viewed as prescriptive. Rather the research must focus on the nurses' interpretations of the constructs contained in the framework, while the analysis must address how, if at all, those constructs were used in practice. This suggested the need to utilize qualitative research methods in the collection and analysis of data.

The remainder of this thesis describes the development of the research, the problems encountered in implementing the research design, the collection and analysis of the data and finally the results of the research and their implications for management and practice. A summary of the content of each of the chapters is given below.

Chapter Two addresses the issues raised above, and describes the methods developed to overcome these problems. It reviews

the methodological shortcomings of traditional approaches to manpower research in nursing. It suggests the need to develop a qualitative, inductive approach to this field of research. However, by introducing a semi-structured framework which was used both to collect and analyse qualitative data, it adapts traditional approaches to qualitative research. The methodological implications of this approach are discussed in this chapter.

Chapter Three describes the first stage of the research; the development of a framework for analysing the contribution made to care by learner nurses. It discusses the framework produced in the light of the problems identified in the first chapter. It concludes with a discussion of how this framework was used to collect data on the contribution made to care by learners. This discussion highlights the importance given to maintaining continuity in the allocation of nurses to patients in much of the literature on individualised care. This indicated the need to examine the effects of the allocation of learners, on the staffing structure found on the research wards.

Chapter Four describes the second stage of the research. It presents an analysis of the staffing structure found on the three wards used in the research. This chapter highlights the difficulties nurses face in maintaining continuity of care for patients. It demonstrates that many of these difficulties were derived primarily from dependence on a learner nurse workforce. The difficulties in maintaining

continuity of care, experienced on each ward, created problems for the organisation of the observational data on each ward. Consequently the original design of the research, presented in Chapter Two, had to be modified to accommodate the instability of the workforce.

Chapter Five introduces the observational stage of the research. It is primarily a methodological chapter which describes the modifications made to the design of the research, in the light of the staffing structures described in Chapter Four.

Chapter Six presents the findings of the observational stage of the research. It describes how these findings emerged from the data collected.

Chapter Seven draws together the findings from the three stages of the research. It discusses the role of the learner nurse specifically, and unqualified nurses generally, in the light of the findings of the research. It also discusses the role of qualified nurses, both permanent and transient, in relation to the role of unqualified staff. It integrates all the data collected in this research to analyse the contribution made to care by the learners observed on the three wards used for observation.

Chapter Eight draws on other literature, in particular that on decision making in organisations, as well as the literature on professional accountability, to extend and

broaden the analysis of the data collected. In doing this it provides a critique of current definitions of individualised care perpetuated in the literature on the nursing process.

Chapter Nine summarises the analysis presented in the two previous chapters and highlights the specific contribution this research makes to an understanding of the role of learner nurses. It goes on to discuss this contribution in the light of the findings of earlier research. It also presents an evaluation of the methods used, and reflects on the strengths and weaknesses of the design of the research. Finally it discusses the implications for further research, which arise out of the findings of this research.

Chapter Two

The Development Of The Research Methods

Introduction

This chapter describes the methodological approach developed in this research in the light of the issues identified at the end of the first chapter. It builds on the critique of nurse manpower planning introduced in the first chapter, and describes the development of a methodology designed to analyse the contribution made by learner nurses to patient care. This methodology incorporates the development of a framework for data collection which took account of changes in the professional ideology of nursing. It was recognised, however, that this framework was itself problematic, and could not, therefore, be imposed on to practitioners; instead the research was designed to identify the nurses' interpretations of the professional and ideological definitions of nursing contained in the framework, and to describe how, if at all, these definitions were used in practice. In order to focus on the contribution made to care by learner nurses data was also collected on how work was allocated to learners, as well as the effects of this allocation on the organisation and continuity of care given at ward level.

METHODS OF DATA COLLECTION

Three methods of data collection were used in this research:-

1.The development of a framework which incorporated professional definitions of nursing.

2.The use of observation and secondary data to identify the effects on the staffing structure produced by the secondment of learner nurses to training wards.

3.The collection of data on the contribution made to patient care by learner nurses, within a framework which reflected professional definitions of nursing practice.

The development of a framework which incorporated professional definitions of nursing

This formed the first stage of the research. The framework was developed using a modified version of the Delphi survey technique. According to Linstone and Turoff (1975) the Delphi survey method is designed to gain the consensus opinions of a group of defined "experts" in situations in which agreement is necessary in order to develop strategies, but in which there exists a diverse range of opinion. This technique was considered to be particularly appropriate in the light of the contradictory definitions of nursing practice, identified in Chapter One.

The Delphi survey technique described by Linstone and Turoff (1975), consists of a number of rounds of questions which are conducted by post in order to minimise individuals being influenced by group responses. In the first round open-ended questions are sent to all participants. In the second round participants are sent all the responses from the first round which have been categorised. They are asked to indicate the priority they would give to each of the responses. Further rounds are conducted until a degree of consensus is achieved. In each round the participants are given the results of the previous round to consider. In some cases

deviant participants may be asked why they maintain this position, their answer will then be circulated to other respondents for them to consider, and possibly alter, their original ordering of priorities.

The Delphi survey appeared, therefore, to provide a means of developing a professional definition of nursing, while at the same time conforming to the principles of qualitative research. The open-ended approach adopted in the first round did not pre-empt the responses of the participants. These can be refined in subsequent rounds to produce a framework which reflects a wider definition of nursing than that which might emerge from the observation of practice on the research wards. It was thought that this approach could provide schedules for observing practice, which reflected a macro definition of nursing, and which was also grounded in the current interpretations of practice held by experienced practitioners.

It was recognised that the framework could have been developed from nursing literature. However, it was felt that if this approach had been adopted it could have produced prescriptive criteria which may not have accommodated contemporary experiences of practice. It would fail, therefore, to capture the complexity of nursing as experienced by practitioners.

A decision was taken, therefore, to send the survey to ward sisters/charge nurses, since because of their position in

nursing, they could be regarded as experts about care. Accordingly 113 ward sisters/charge nurses working in 21 different clinical specialities participated in the survey. In the first round they were sent open-ended questionnaires which gave case studies of three different patients of high, medium and low dependency, respectively (see Appendix D). The nurses were asked to identify the care needs of each patient, and to give their reasons for selecting those aspects of care.

The analysis of the data collected in the first round suggested that the second round of the survey, which asks respondents to prioritise the findings of the first round, was inappropriate for two reasons. Firstly, it was recognised that nursing actions could only be prioritised in the context of the needs of a specific patient. Secondly, it was recognised that the development of a framework which identified nursing actions, would either be unweildly, because so many actions were identified, or prescriptive, if the number were reduced. Therefore, a decision was taken to concentrate on the reasons nurses gave for various nursing actions. This produced "aims of care" for patients in each dependency group, for a range of activities of living. In the light of this adaptation, the second round was modified and the respondents were merely asked to validate the analysis of the first round.

Observation schedules were developed from the second round of the survey. The schedules incorporated aims of care for a

range of activities of living for each level of dependency (see Appendix E). These were used during the observation stage of the research to structure the data collection, and as framework for analysing the observational data.

A modified Delphi survey method was used, therefore, to derive a professional framework for analysing the contribution made by unqualified learners, using information provided by sisters/charge nurses who are primarily responsible for determining the content and supervising the implementation of such care. Ward sisters and Charge nurses are the clinical specialists in nursing whose knowledge, experience and position gives them the potential to act as professional practitioners. It seemed appropriate, therefore, to use their interpretations of nursing practice as a framework for identifying the contribution made to care by learners.

<u>The use of observation and secondary data to identify the effects on staffing structure produced by the secondment of learner nurses to nurse training wards.</u>

The decision to analyse the effects on the staffing structures of nurse training wards produced by the allocation of learners as part of the workforce arose from the problems of maintaining continuity of care, as described in the first chapter. This suggested the need to identify how patient allocation operated on the research wards and the degree of continuity of care achieved on these wards

This data was therefore collected on the three nurse

training wards used during the observation stage of the research. These wards were located in one District Health Authority and consisted of:-

A thirty bedded long-stay geriatric ward
A twenty-eight bedded acute medical ward
A twenty-two bedded gynaecology ward.

These wards are described in Appendix F.

The data collection consisted of:-

1.A comparison of the funded staffing establishment with the actual staffing establishment found on each ward at the time of the research. This indicated that learner nurses accounted for a high proportion of the funded staffing establishment on each ward. However observation of the actual numbers of learners on the ward during the research suggested that this fluctuated substantially around the establishment figure.

2.Fluctuations in the allocation of learners to the wards was found to be an important factor influencing the organisation of care on each ward. For this reason more extensive data was collected on the allocation of learners to each of the wards. This was derived from an analysis of the duty-rostas on each ward for periods of approximately one year prior to the period of observation (a detailed discussion of this aspect of the research is given in Chapter Four). Duty-rostas were analysed because these are working documents used on each ward to plan the organisation

of care. Therefore, last minute alterations in the allocation of learners are more likely to be noted on these documents since they are used to identify the availability of nurses and may need to be changed in the light of such alterations. For this reason it was felt they were likely to be more accurate than other sources of information on the allocation of learners to wards.

3.Data was also collected on the utilisation of bank and agency nurses by each of the three wards. This arose out of a recognition, early on in the research, that the demand for these nurses was in part derived from an under-allocation of the learners to the wards. Retrospective data on the demand made by each ward for these nurses was patchy, therefore the data collection involved only those agency and bank nurses observed by the researcher.

4.A complete description of the number and grade of nurses on duty was recorded at the beginning of each shift, along with the patients each nurse was allocated to care for. Nurses and patients were individually coded. This enabled an analysis of the degree of continuity each ward was able to achieve in the allocation of nurses to patients, while maintaining the anonymity of the individuals involved. The coding index was destroyed at the end of the period of observation. Again, this data was collected because it was found that the need to provide adequate supervision of learners influenced the system of patient allocation used on each ward.

The analysis of this data, which is given in Chapter Four, was used to underpin the interpretation of the observational data.

The collection of data on the contribution made to patient care by learner nurses, within a framework which reflected professional definitions of nursing practice.

This formed the third area of data collection. Participant observation was undertaken on the three wards given above. However, the role of the observer was adapted to accommodate the structuring of the data collection. This is described below:-

1.Once the nurses had been introduced to the research, a group of patients was identified, to whom, where possible, a learner nurse had been allocated. The nurses working with these patients were asked to complete a nursing assessment on each patient which was designed to identify the patient's level of dependency (see Appendix G).

2.From these assessments a patient was selected, by the researcher for observation. The criteria used for selection is discussed in Chapter Five.

3.The assessment indicated the patient's dependency level. Observation schedules, derived from the Delphi survey, which reflected this dependency level were then used to structure the data collection.

4.The nurses caring for the patient were asked to read through the appropriate observation schedules. These

identified aims of care for a range of activities of living (see Appendix E). They were asked to identify which, if any, of the aims of care listed, reflected the needs of the patient under observation during the forthcoming shift. If they identified any aims of care, they were then asked to describe how they intended to implement them. This was noted on the observation schedule alongside the corresponding aim of care. Non-participant observation was then undertaken of the care given to the patient and noted on the observation schedule under the appropriate activity of living. The period of observation lasted for the remainder of the shift.

5.The grades of nurses giving each aspect of care was also noted.

6.If the opportunity arose, the nurses were asked to comment at the end of the shift, on the care they had given.

The method described above presents an ideal type and was not consistently achieved throughout the research. One of the main reasons for this was the unstable and fluctuating staffing structure, which was characteristic of these wards. This meant that too much data had to be collected early on in the shift by nurses who did not necessarily know the patient well enough to undertake the assessment. Neither did they have the time to complete the observation schedules. For these reasons the method had to be adapted to accommodate the organisation of care on each ward. The adaptations made to this method are described in Chapter

Five.

The above method was designed to make explicit the nursing plans for each patient observed and to contrast this with the care actually given. The aims of care included in the observation schedules reflected a diverse range of definitions of nursing derived from the survey. This method enabled an analysis of the predominant definitions of nursing found on each of the three wards as well as the patient groups to whom they were applied. It also allowed the nurses to reject aims of care which they considered not to be relevant to the needs of a given patient, or, as was frequently the case, too difficult to implement in practice. It did not, therefore, impose any one definition of nursing onto the nurses. Instead it enabled the nurses to make explicit the nursing framework they were using to determine practice. This data was used to develop an analysis of the contribution learners made to maintaining the predominant definitions of nursing found on each ward.

From the above description of the observation undertaken during this research, it is clear that participant observation was used as the main method of data collection during this stage of the research. However, this method was adapted in order to focus on the issues highlighted at the end of the first chapter. According to Burgess (1982), "Participant observation is not merely a method of conducting field research, but also a role that is used by the researcher" (Burgess 1982 p.45). Becker (1970) suggests

that the participant observer collects data by taking part in the everyday life of the people involved in the situation under study. This type of data collection is therefore characterised by the researchers involvement in the situation being studied, as it is only then that they gain access to the full range of factors that may influence or constrain behaviour.

Gold (1958) identified four "master roles" for participant observation:- (i) The complete participant; here the researcher enters the situation as a new group member and does not reveal the research objectives of participation. (ii) Participant-as-observer; here the researcher participates fully in the groups activities, but their role as a researcher is known to all group members. (iii) Observer-as-participant; here greater emphasis is given to the observation and the researcher only participates when it facilitates observation. (iv) Complete observer; in which there is no participation by the researcher in the group activities. These "master roles" represent ideal types. In practice a researcher may adopt more than one of these roles during the course of observation.

The role adopted in this research lay between the observer-as-participant role and participant-as-observer role. In his description of the observer-as-participant role, Gold (1958) suggests that the degree of involvement by the researcher is minimal, usually limited to one visit. In this research

between two and three months was spent on each ward collecting data. This involved extensive discussions with the nurses about the care they gave; consequently the role adopted was more like that of participant-as-observer. This role implies extensive involvement by the researcher in group activities in order to become familiar with all the possible influences on behaviour. However, in this case participation was limited to discussions about care and there was very little actual involvement in the provision of care. Here the role of an observer was adopted.

The adoption of this role within the parameters of participant observation was considered to be the most appropriate method of data collection since it provided an opportunity to explore with the nurses their interpretation of the nursing needs of patients, and how these could be met within the ward environment. Observation of the care actually given could then be undertaken, and analysed within the context of the nurses own definition of the patient's nursing needs. Full participation in care giving was found to be inappropriate in this research as the aim was to analyse the contribution made to care by learners within the prevailing staffing structure. The addition of an extra qualified member of staff in the form of the researcher would change this staffing structure, and this might affect the learner nurses contribution. Full participation also imposed the researchers own definitions of care onto the ward environment; while this facilitated an analysis of how

these definitions could be implemented in practice, it impeded an analysis of the contribution given by learners. During preliminary pilot work it was found to be impossible to both give care and make accurate observations of the care given by others.

THE DEVELOPMENT OF A QUALITATIVE METHODOLOGY FOR NURSE MANPOWER PLANNING

The development of the above methods draws on, and utilizes many of the tenets which underpin qualitative, inductive approaches to research. The adoption of a qualitative approach in this research reflects difficulties identified with traditional manpower planning methodologies. It recognises that nursing does not have discrete and easily identifiable parameters. Instead it is an emergent construct which is socially defined, and which incorporates a variety of moral and philosophical values that may at times conflict. These values give rise to dilemmas which do not have an immediate or obvious mechanistic solution. Instead they require nurses to make judgements about practice. These judgements reflect nurses attempts to resolve dilemmas and may not always give rise to predictable or measurable behaviour.

For this reason the framework for observing practice was derived from practising nurses. During the observation stage of the research it was not imposed on the nurses. Instead the research sought to identify how the nurses resolved the dilemmas inherent in practice. However, as this chapter

indicates, the introduction of semi-structured observation schedules to the research wards, presents problems, as the categories for analysis were not derived directly from observations of that practice. Instead they reflected wider issues in nursing which could not always be accommodated in the research wards.

The Principles Of Qualitative Research

Schon (1983), in his critique of technical rationality, suggests that the positivist philosophy from which it is derived assumes that there is an "objectively knowable world, independent of the practitioner's values and views" (Schon 1983 p.163). Understanding this world involves distancing oneself from it and making it an object of inquiry. However, in practice, Schon suggests professionals must enter into a dialogue with this world. It is through reflection that the practitioner shapes a situation and so gives meaning to it. Therefore, the sense of a situation must include the practitioner's contribution to shaping it.

The reflective nature of professional practice described by Schon appears to correspond with the principles of qualitative research. This type of research rejects attempts to produce objective descriptions of social phenomena, as the qualitative researcher recognises that these are constructed from the meaning and understanding that individuals bring to the social situation, and that this will determine the behaviour adopted.

Hewitt (1979), in a discussion of symbolic interactionism suggests that qualitative research is derived from pragmatic philosophy. This recognises that, in order to understand behaviour, it is necessary to examine the assumptions and pre-suppositions of the actors concerned. In other words the central question is how the actors interpret a situation as this will determine their behaviour. The truthfulness or accuracy of that interpretation is not the issue, as this suggests that a factual or objective description can somehow be achieved, and that the behaviour was in some way mistaken because it was based on a false premise. Symbolic interactionism suggests instead, that it is necessary to explain why the behaviour was adopted and what motivated the behaviour in the first place. This can only be achieved by developing an understanding of the beliefs and assumptions from which it arose.

Similarly, Halfpenny (1979) distinguishes between qualitative data as it is used in positivist (macro correlational) sociology to identify emergent concepts prior to causal (statistical) analysis, from qualitative data as it is used in the interpretivist school of sociology. Interpretivist sociology he suggests is concerned to authentically capture the meanings of actions and interactions current among the people under study. "Adherence to the interpretivist approach is often signalled by appeals to construct a sociology that accords full importance to the intrinsic meaningfulness of the actions

which are its data". (Halfpenny 1979 p.816). Failure to do this, he suggests, runs the risk of violating the integrity of subjective experience. Consequently the analysis is grounded in the culture under study. As Silverman (1985) suggests, qualitative research develops a micro analysis which produces descriptions and explanations appropriate to the way people actually behave.

The descriptions of qualitative research given above, suggest that validity in the analysis of qualitative data is achieved by demonstrating congruity between the sociologists analysis of action, and the accounts given by the actors. The unstructured, or open nature of the data collected using participant observation, challenges the pre-suppositions of the researcher. This enables new and novel interpretations to emerge from the analysis, which reveal the beliefs and assumptions of the research subjects, and does not impose those of the researcher.

This description of qualitative research appears, therefore to preclude the possibility of introducing alternative formulations of behaviour to the situation under observation. It implies that any alternative formulations may not be compatible with the actor's own accounts. This indicates that the use of the Delphi survey method to develop a framework for collecting and analysing data on the role of the learner nurse may well be incompatible with traditional formulations of qualitative research. Although this framework was not imposed on the nurses, it did

introduce definitions of practice which were not derived directly from the situation under observation. As a result the analysis may not reflect the definitions of practice used on the research wards. The analysis of the research therefore had to bring two distinct data sets together.

This problem has been addressed by Silverman (1985) who points out that the traditional approach to qualitative research described above, tends to blur the distinction between folk accounts of behaviour and sociological interpretations of action, which may reduce the scientific status of sociology. Silverman suggests that part of the problem surrounding the status of actors' accounts can be traced back to the use of observation and interview as a methodological technique. He cites Moerman (1974) a cognitive anthropologist, who recognised that the use of the naive question from the 'outsider' researcher frequently relates to issues which are, from the natives point of view, obvious or non-existent. Therefore, as Moerman suggests, answering the sociologists questions forces the actor to use categorisations which may not reflect their normal descriptions. Consequently the analysis produced cannot be said to reflect the normal meanings attached to behaviour by the actor.

Bryman (1988) makes a similar point in his discussion of the problems of qualitative research, when he suggests that "ethnographers rarely adopt a stance of being 'sponges'

whereby they simply absorb subjects' interpretations. Very often they exhibit a focus of interest though usually couched in very broad terms, which may not be part of their subjects' viewpoints" (Bryman 1988 p.73). The problem that both Silverman and Bryman appear to be addressing is the role of explanation and theory development in qualitative research. Explanation, they suggest, will necessarily incorporate the researchers prior sociological and personal knowledge of the subject, which may well have given rise to a desire to study a particular issue in the first place. Theory development implies the need to link the findings of each study to other studies in order to develop a comprehensive body of knowledge. Limiting explanations and theory development to the subjective interpretations of the actors under study reduces the amount of knowledge that can be used to analyse the data, and therefore limits the development of theory within the subject.

This problem is particularly pertinent in nursing research where the researcher also has a nursing background and therefore may share, with the nurses, many of the assumptions underpinning practice. Under these circumstances the use of the naive question, to elicit the meaning underpinning action, may sound absurd to the nurses. For instance, the question "Why did you give that patient a bedpan?" could elicit the response "because she asked for one!" The answer was therefore obvious and the question sounds silly. The real question "Why did you give her a

bedpan and not a commode or take her out to the toilet?" remains both unasked and unanswered. This would appear to be a trivial problem, easily resolved by reframing the question.

However, it is not a naive question. As the analysis given in Chapter One demonstrates it is prompted by a particular conception of nursing, which is derived from a social definition of health and illness. A definition which emphasises the promotion of independence and autonomy in patients as a central aim of nursing care. The problem with adopting participant observation as a framework for data collection and asking these questions, lies in the interpretation of action. Hammersley and Atkinson (1983) point out that, in adopting a naturalistic perspective, the explanation given by the researcher must accord with that of the nurse, otherwise the intrinsic meaningfulness of nursing actions to the nurses, is violated. However, as they subsequently point out, in adopting this position the researcher is assuming, in principle at least, that it is possible to isolate a body of data uncontaminated by the researcher. The researcher is therefore seeking objectivity in much the same way as positivist sociology attempts to do. Consequently, the purpose of the research is simply to give expression to the intrinsic meanings that actors use to make sense of the social world. However, as the question about the use of the bedpan given above suggests, the researchers perspectives will necessarily contaminate the data.

Hammersley and Atkinson (1983) go on to suggest that there is a central dilemma in qualitative research between attempts to capture the realism of the culture under study in an authentic manner which accepts only actors accounts as plausible explanations, and a recognition that all encounters are interactive and the researcher must, by their mere presence, interact with the environment and influence the actors understanding of actions. They suggest this dilemma is overcome once it is recognised that all research involves selection and interpretation. In other words research is by definition characterised by reflection on the data collected, and that as a researcher it is never possible to be external to society or the culture under study. Consequently, there is no external conclusive standard for judging data. Instead we must work with the knowledge we have. Once this is recognised, reflection ceases to be a source of bias , and becomes an integral part of the research process. This appears to be particularly relevant to practice research, where it is clear that the researcher's interpretation of nursing informed the data collection, and is therefore likely to shape responses in the way described by Moerman (1974) above.

The formulation of qualitative research given by Silverman (1985) and Hammersley and Atkinson (1983) appear therefore to recognise and support the development of analytical frameworks which are not wholly derived from the contextual situation under analysis. It is suggested therefore that the

use of the Delphi survey method to develop a framework for analysing practice, and the sharing of this framework with the nurses under observation, reflects the descriptions of qualitative research given by Silverman (1985) and by Hammersley and Atkinson (1983).

The adoption of this approach to qualitative research does give rise, however, to problems of validity, as it is no longer possible to validate the findings by reference to the actors own accounts of their behaviour. This gave rise to the adoption of an alternative method for analysing the data.

THE METHOD OF ANALYSIS USED IN THIS RESEARCH

The above discussion suggests that claims to validity in qualitative research are based on developing "an understanding of the meaningful worlds in which people act..." which allow people to "...tell their own story in their own words" (Hewitt 1979 p.260). However, as Hewitt recognises, inevitably the researcher brings their own experiences and preconceptions to the research process. This is overcome, he suggests, by the collection of unstructured data, which means that the analysis will not be limited by the researcher's assumptions, which are, in fact, challenged during the course of data collection.

Claims to validity in qualitative research therefore tend to rest on demonstrating congruity between the researchers accounts of action, and those of the actors or members studied. However, if, as in the case of this research, a

semi-structured approach to data collection is adopted, in which the researcher's preconceptions about nursing can be seen clearly to influence data collection and analysis, then claims to validity cannot rest on the production of an adequate description of nursing work. Instead, some other means must be sought for validating the subsequent analysis of the data.

Silverman (1985) draws on the work of ethnographers, and in particular their use of the logic of analytical induction, as an alternative approach to validating qualitative research. He suggests that whatever their theoretical presuppositions, ethnographers share a common problem, they lack a sound means of developing and validating generalisations. As Halfpenny (1979) recognises, validating the analysis by grounding it in the culture under study generates, for the researcher, the problem of understanding more than one culture, of comparing findings, or of generalising from the context of analysis to another contextual situation. Silverman suggests that analytical induction is a method that can be used by qualitative researchers or ethnographers to try to formulate generalisations which hold across all the data collected. He cites the six stages involved in the use of the method as described by Denzin (1970).

1.A rough definition of the phenomenon to be explained is formulated.

2.A hypothetical explanation of that phenomenon is

formulated.

3.One case is studied in the light of the hypothesis, with the object of determining whether or not the hypothesis fits the facts in that case.

4.If the hypothesis does not fit the facts, either the hypothesis is reformulated or the phenomenon to be explained is redefined so that the case is excluded.

5.Practical certainty may be attained after a small number of cases has been examined, but the discovery of negative cases disproves the explanation and requires a reformulation.

6.This procedure of examining cases, redefining the phenomenon, and reformulating the hypothesis is continued until a universal relationship is established, each negative case calling for a redefinition, or a reformulation.

(Taken from Silverman 1985 p.112)

Silverman maintains that the use of analytical induction offers the potential for rapprochement between macro and micro perspectives in sociology by drawing on elements that are essential to both perspectives.

The use of analytical induction in qualitative methodology proceeds via the use of descriptive case study material. Znaniecki (1934), an early proponent of analytical induction, describes its general principles as "an attempt to discover some final truths about a certain class of empirical data, circumscribed in advance, by studying a number of cases belonging to this class. Originally and fundamentally, the truths sought for are to be characters common to all data of the given class and only to these" (Znaniecki 1934 p.222). From Znaniecki's description it is clear that in using analytical induction the researcher tries to accurately capture the complete quality of the data

under analysis. In so doing, the strengths of the interactionist or interpretivist schools of sociology, in maintaining the integrity of the subjective experience, can be incorporated into the analysis of the data. However, at the same time the use of deviant cases, in an attempt at falsification and reformulation, provides the method by which the explanatory theory evolving from the analysis is subjected to scientific or logical validation. In this way the rapprochement sought by Silverman, between the macro and micro perspectives in sociology, is developed.

This overcomes the anecdotal character of qualitative analysis as it is sometimes practised within an interactionist or interpretivist framework. As Silverman suggests, the use of analytical induction, in which the researcher actively searches for data which falsifies their own propositions and then attempts to reformulate their analysis to incorporate deviant cases, goes some way towards a forced expression, in the interpretation given, of the full range of qualitative data collected. Halfpenny (1979) suggests that this introduces to qualitative analysis a Popperian version of positivist research, namely that cases or events can be used as a means of falsifying existing theory. Halfpenny considers, therefore, that this approach adopts an essentially positivist orientation, as it is ultimately concerned to identify causal explanations between variables through the process of refutation and reformulation. Silverman (1985) counters this suggestion by

asserting that "the function of research, as opposed to journalism, is to develop and test theories" (Silverman 1985 p.116), and rigorous scientific means must be used to achieve this. In other words it is not the subjective meanings underpinning action which are falsified using analytical induction, but the subjective interpretations of data by the sociologist.

In order to address the issue of validity in qualitative research this research utilized the framework of analytical induction in the analysis of the data collected. A working hypothesis or proposition about ward nursing was generated from the Delphi survey. This proposition was analysed in the light of the data collected in the second and third stages of the research. This analysis is given in Chapter Seven. In order to conform to the principles of analytical induction all of the data collected in each of the three stages of the research was included in this analysis. The analysis therefore had to incorporate both the definitions of nursing which arose from the Delphi survey, and those that emerged from the observations of patient care. It also had to focus on the contribution made by learners to constraining or maintaining, the various definitions identified. This was achieved by integrating the data obtained on staffing structures with the data derived from the Delphi survey and from observations of practice. As the thesis demonstrates, the staffing structure, and its effects on the organisation of care, emerged as the critical factor which sustained two

distinct definitions of nursing, and constrained any merger from taking place between them.

A second check on the introduction of selective bias in the analysis of qualitative data suggested by Silverman (1985), is the use of simple techniques of quantification. He suggests that simple counting procedures can be a useful tool in qualitative methodology. The analysis of the data within analytical induction focuses on the examination of selected cases derived from the mass of qualitative descriptive data. In developing an analysis of the data the researcher has to be able to indicate that the cases selected and analysed were typical of the pattern of events from which they are derived. Simple counting procedures Silverman suggests can be used to convey a picture of the whole mass of descriptive qualitative data in summary form. Counting can therefore be used by the researcher to counter suggestions that data depicted in the analysis merely reflects subjectively selected information which supports the researcher's interpretation of the data.

Where possible, descriptive counting was used in the analysis of the data collected in this research. It forms the main content of the analysis of the staffing structure, and it is also used to indicate the range of unstructured data collected in the modified Delphi survey and during the course of observation. However, the use of counting is not straight-forward. It again gives rise to problems of categorisation, particularly in the observation data, which

was collected in the context of the care given to a specific patient. It was found that counting statements or priorities highlighted by the nurses on the observation schedules, gave rise to some questionable results. For instance, on the observation schedule the nurse might be asked whether they thought giving a patient a choice about food was "Necessary", "Not Necessary", "Achieved" or "Not Possible" (see Appendix E). On a number of occasions "Not Necessary" was ticked by the nurse. However, in each case it was found that there were special circumstances surrounding this patients nutritional needs that explained why that box was ticked. The patient could, for instance, be "Nil By Mouth", or on a highly specialised diet. Therefore, the priorities given for an individual case, may not reflect the nurse's general priorities for care. Where data was collected in such a way that it could be counted, and it made sense to do so, then it was counted and the results given. Where counting was not possible, traditional approaches to the presentation of qualitative data are used. This involves generalised description supported by case study material.

TOWARDS A RESOLUTION OF METHODOLOGICAL PROBLEMS IN NURSE MANPOWER PLANNING

This section returns to the methodological problems which emerged at the end of the first chapter. It describes how the methods used in this research attempted to overcome these problems.

As discussed in Chapter One this research arose out of a

critique of traditional approaches to nurse manpower planning. This highlighted the reliance placed by nurse manpower planners on the techniques of operational research, which, it was suggested, gave rise to a number of assumptions about nursing practice which do not accord with contemporary developments in nursing knowledge and ideology.

The first problem highlighted at the end of the previous chapter, was the need to develop a framework for manpower planning which reflected the professional aspirations of nursing. It was suggested that the emphasis placed, by operational research, on empirical method to the detriment of theory development, gave rise to a hierarchical definition of nursing practice in which basic nursing care is defined as unskilled. It therefore assumed that this care can be implemented by unqualified nurses. This fails to recognise that this definition may arise out of the traditional reliance in nursing on unqualified staff. Instead manpower planners have assumed that the only definition of nursing is that which operates on the ward, and that by definition nurses provide a professional standard of care. As Chapter One illustrated, this assumption is ill-founded, and has been disputed by numerous studies of clinical practice. By grounding their research in the current organisation of practice, nurse manpower planners have been unable to provide an analysis of skill mix, as they have failed to address the issue of what constitutes skilled nursing.

This gave rise to the need to develop a framework which reflected contemporary developments in nursing knowledge in order to produce a theoretical analysis of the contribution made by different grades of nurses, in particular learners, to the provision of skilled nursing care. The Delphi survey technique was used to develop this framework as it provided a method for obtaining the views of qualified practising nurses on their interpretations of skilled nursing care.

The second problem highlighted at the end of the previous chapter was the effects on ward organisation of dependence on a transient learner workforce. As discussed in the previous chapter contemporary developments in nursing knowledge and ideology were promoted in nursing via the introduction of the nursing process and systems of patient allocation. These advocated a devolution of decision making about care to the point of implementation in order to involve the patient more centrally in the decision making process. However, the role and decision making capacity of the learner nurse, was not adequately resolved in the literature. This gave rise to the need to consider how the allocation of learners to hospital wards affected the organisation of care on those wards. It raised questions about how work was allocated to learners; the availability of qualified staff to supervise the practice of learners; and the degree of continuity in the allocation of nurses to patients achieved on the ward.

If we return to traditional manpower methodologies, it was clear that they did not address these issues at all. In fact it is possible to argue that they served only to perpetuate many of the problems associated with a transient workforce. The aim of traditional approaches to nurse manpower planning is to produce an efficient utilisation of available nursing staff. This has resulted in the development of complex formulae which are designed to provide increasingly accurate measurements of nursing workload. These tools therefore, operate by constantly redeploying nurses in response to measured fluctuations in workload. As a recent review of dependency scales (South East Thames Regional Health Authority 1987) suggests, the need to produce standardised measurements of nursing activities which can be transferred to other units, for the purpose of comparison, has resulted in smaller and smaller elements of nursing being measured. As a result the tools produced by manpower planners are becoming increasingly time consuming for the nurses to complete, while the information returned is not particularly useful, as nurses can only be redeployed in hours not minutes.

It follows, therefore, that the utilization of these tools by nurse managers may result in the perpetuation of staffing structures which reinforce many of the assumptions about nursing inherent in the formulation of these tools. This suggests that the continued use of these tools will tend to perpetuate definitions of basic nursing care as unskilled;

reinforce an analysis of workload which is dominated by tasks that are amenable to timing; and fail to accommodate workload that is generated by aspects of nursing which are not easily subjected to timing, such as communication, counselling and the support of relatives and patients. These are all aspects of nursing care which have been subject to extensive criticism.

Finally the adoption of these tools undermines continuity of care by continually redeploying nurses in response to measured changes in workload. These methods therefore merely replicate current practice and are unable to assess the consequences for both efficient and effective practice of alternative organisations of staffing, such as a stable workforce with a different mix of skills. It is suggested therefore that the continued use of these tools by nurse managers may merely serve to reinforce historical patterns of nurse staffing. While the possibility that these staffing patterns act as a structural constraint on the development of a more individualised approach to care, remains unconsidered. This criticism of manpower planning gave rise to the second area of data collection, namely, the analysis of the staffing structure on the research wards and the effects on the organisation of care produced by dependence on a learner nurse workforce.

The emergence of competing definitions of nursing from the Delphi survey reinforced the analysis given in Chapter One which suggested that nursing was dominated by more than one

conceptual framework. This highlights the third concern identified at the end of the previous chapter, namely how to accommodate the competing definitions of nursing found in the literature, and develop a methodology that was sensitive to this problem. The utilization of a qualitative perspective in the development of the observational framework recognised the importance of identifying the range of definitions of nursing recognised by practising nurses. Similarly the use of a qualitative perspective in the collection of the observation data enabled the research to address the issue of how nurses interpreted the definitions of nursing contained in the framework, in practice.

This research, focuses therefore on the subjective elements of nursing practice. In so doing it moves away from the development of objective formulae which have come to characterise nurse manpower planning. However, it is possible to argue that this approach merely highlights subjective elements that have remained buried within the development of these formulae. As the review of dependency studies carried out by the South East Thames Regional Health Authority (1987) points out, the focus on objectivity through timing, which dominates this field of research, conceals the subjective elements which were found in all the tools reviewed. The review found that when using these tools nurses are invariably asked to make judgements about aspects of nursing care. For instance, they may be asked to state the number of nurses actually required to mobilise or

blanket bath a given patient. This question may well turn on the degree of skill available on a ward. The review suggests therefore, that the complexity of these tools does not resolve the fundamental problem of subjectivity. In developing this approach to nurse manpower planning, this research recognised the essentially subjective nature of the decisions taken by nurses in relation to workload, and sought to provide nurses with a framework which would enable them to make this process explicit.

The final methodological issue highlighted at the end of the previous chapter, was the problem of grounding the analysis in observations of contemporary practice. It was recognised that undertaking a qualitative analysis of nursing work may, like the empirical observations undertaken by nurse manpower planners, simply reinforce contemporary definitions of basic nursing care as unskilled. The introduction of a semi-structured approach to the collection of qualitative observational data, via the development of the observation schedules from the Delphi survey, went some way towards overcoming this problem. It was designed to provide a method which would enable nurses to distinguish between, their aspirations for patient care, and the realities of their practice.

However, as the research proceeded it was found that the definitions of nursing which emerged from the Delphi survey were very different from those in use on the research wards.

This gave rise to the problem of which definition of nursing to accept as valid as both arose from practising nurses. Therefore a method of analysis had to be adopted which would resolve the contradictions that arose in the data collection. As described above, this problem was addressed by using the method of analytical induction. This method seemed particularly appropriate as it allows the researcher to draw on knowledge gained outside the research setting. This includes in this case, personal experiences of practice, as well as other literature, to generate theoretical propositions which could explain the data. The final interpretation given must however, encompass the totality of the data collected. This method was used therefore, to bridge the gap between definitions of nursing which reflect contemporary developments in nursing knowledge and the realities of practice which continue to produce definitions of basic nursing care as unskilled.

SUMMARY

This chapter describes the development of a methodology which was designed to address the issue of skill mix in nurse manpower planning. It was developed primarily to analyse the contribution made by learner nurses to patient care. The methods described in this chapter represent an attempt to overcome limitations identified with traditional approaches to nurse manpower planning. It presents an attempt to introduce to nurse manpower planning, a conceptual framework for analysing nursing practice, which

incorporates contemporary developments in nursing knowledge and ideology. However, it recognises that the framework produced is not prescriptive, but open to interpretation, refinement and redefinition by nurses during the course of practice.

The next chapter describes the development of the Delphi survey as it was used in this research. It explains the modifications that were made to this method following the analysis of the first round of the survey. Finally, the data collected from the survey is used to generate the first working hypothesis, or proposition about nursing, which forms the starting point for the process of analytical induction.

Chapter Three

The Development of the Methodology: Utilizing the Delphi Survey Method

Introduction

This chapter describes the first stage of the research, the development and use of the Delphi survey technique to produce a conceptual framework for analysing nursing practice. It begins with a brief description of the technique as it was developed by Linstone and Turoff (1975) and discusses the modifications that were made to this technique, in order to avoid the development of a prescriptive framework for practice. Finally, it presents the results of the survey and produces a working hypothesis or proposition about nursing, which arises from an analysis of these results. This forms the first stage in the process of analytical induction described in Chapter Seven which was used to produce a theoretical analysis of the data collected in this research.

THE DELPHI SURVEY METHOD

As discussed in Chapter Two the Delphi survey method is designed to develop a consensus among experts in situations where the literature on a given subject is ambiguous. It utilizes a postal questionnaire, which is designed to elicit the opinions of a group of experts in the field. The results are collated and fedback to the respondents, who are asked to prioritise the responses. This process is continued until a consensus is achieved.

The Delphi survey appeared, therefore, to provide a means of developing a professional definition of nursing, while at the same time conforming to the principles of qualitative research. The open-ended approach adopted in the first round did not pre-empt the responses of the participants. These were refined in subsequent rounds to produce a framework which reflected a wider definition of nursing than that which would emerge from the observation of practice on the three research wards. It was thought that this approach could provide schedules for observing practice, which reflected a macro definition of nursing, and which was also grounded in the current interpretations of practice held by experienced practitioners.

THE DEVELOPMENT OF A FRAMEWORK FOR CONDUCTING THE SURVEY

In order to utilise the Delphi survey method it was necessary to develop a framework from which a professional definition of nursing could be derived. A possible technique appeared to be the development of a case study, which could be used as a focus for identifying current approaches to practice thought appropriate by the nurses who participated in the survey. Clearly, however, any definition generated would be constrained by the case study, and therefore the extent to which it could be generalised to other situations would be limited. This is where the research into manpower planning proved to be particularly useful.

The concept of patient dependency developed by operational

researchers evolved out of an analysis of the content of nursing work. In developing criteria which reflect nursing work, it is noticeable that on no occasion do manpower studies use differentiation by disease as a basis for identifying the demands made by patients on nursing time. Although it is recognised that it is the disease process that gives rise to dependency, the basic care given by nurses focuses primarily on the physical and psychological needs that arise out of the disease process, and not on the cure or treatment of the disease. As previous manpower studies found (Barr 1967, Scottish North-Eastern Hospital Board 1969, Cheltenham and District Health Authority 1983, Ball, Goldstone and Collier 1984), diverse disease processes can manifest similar dependency states. Nursing work appears, therefore, to be more coherently categorised using dependency than using diagnosis. For instance, a person who is left severely paralysed following a cerebral vascular accident may make similar demands on nurses as a patient with a head injury, or a patient suffering from cerebral cancer. All of these may experience paralysis but possess a very different diagnosis, and will therefore be subject to very different forms of medical care.

The focus on patient dependency would appear to correspond with current developments in academic nursing. Henderson (1966), Bower and Bevis (1979), Roper Tierney and Logan (1980), and Orem (1980), for example, all produced models which focused on the promotion of independence as a specific

nursing responsibility. There appeared therefore, to be a link between dependency and the concept of independence, which underpins the social model of health, and the introduction of individualised care. For this reason, the concept of patient dependency was adapted to provide a framework for developing the Delphi survey.

The Development of a Method for Assessing Patient Dependency

The development of a method for assessing patient dependency formed the first part of this stage of the research. The development and use of an assessment tool served a number of purposes. Firstly, it enabled the identification of a set of characteristics which could be used to group patients with disparate diagnosis. These characteristics reflected the nursing needs of patients in each dependency grouping regardless of diagnosis. From these characteristics, case studies were developed which reflected the needs of patients in each dependency grouping for basic nursing care. The case studies formed the basis for the Delphi survey. Secondly, the dependency classification was used to assess patients during the observation stage of the research, in order to link the care they were given with that identified in the survey.

Numerous studies into nurse manpower planning have been undertaken using patient dependency. As yet, however, no consensus exists as to the number of levels of dependency to use, or how to set the parameters on each dependency

grouping. Most patient dependency studies undertaken for the purposes of nurse manpower planning group patients according to the demands they make on nursing time. As a result they tend to utilise physical characteristics, such as mobility, to identify dependency levels (Barr 1967, Scottish North Eastern Hospital Board 1969). However, as Rhys-Hearn (1973), recognised concentrating on levels of physical capacity only, created dependency groupings which lacked any homogeneity, as the psychological capacity of patients in each category could be extremely diverse, and this could have an unequal effect on their demand for nursing care.

At the time of the research, Rhys-Hearn (1977) was developing a dependency rating which aimed to incorporate both the physical and psychological capacity of the patient. Her work was, however, restricted to the elderly. While it is probable that it could be transferred into the acute sector, this would need to be tested. Moreover, as her work was primarily concerned with manpower planning, she too focused on timing nursing activities. Consequently the framework used by Rhys-Hearn was subject to the problems inherent in manpower planning, described in the first two chapters. For the reasons given in the first two chapters, the approaches to measuring patient dependency, developed by operational research, were considered to be inappropriate to the aims of this research.

The Development of a Professional Assessment of Dependency

In response to these problems, Hunt (1982) developed a progressive scoring assessment of the patient's capacity to cope with daily living activities. This was designed to be easy to use, and to facilitate and clarify subjective judgements. It did not claim to develop an objective assessment, as it was recognised that this would require a standardised definition of nursing which is inappropriate in a professional occupation. It was based on the work of Henderson (1966) and utilised key components derived from the work of Norton et.al. (1975) and Rhys-Hearn (1977). The nursing assessment was developed in conjunction with a group of District Nurses who wanted to facilitate the transfer of care between the hospital and the community nursing service. The district nurses refined the work of Henderson, Norton and Rhys-Hearn by identifying those activities of living which appeared, in practice, to require assessment. For each activity of living selected by the nurses, the patient is given a score 0, 1, 2, or 3 (see Appendix G). 0 signifies the patient is totally independent for that activity of living, 3 indicates the patient is totally dependent on nursing for that activity of living to be maintained, and 1 and 2 are graded in between for each activity of living.

The nursing assessment designed by Hunt (1982) incorporates aspects of the patient's level of physical, psychological, and social dependence. Certain activities of living are excluded from the assessment, such as sleep and respiration.

They were excluded by the district nurses, not because they were considered unimportant, but because they do not directly contribute to an increase in dependency. Any increase in dependency arising out of impaired respiratory function or sleep will manifest itself as an increase in physical and/or psychological dependency, which will be picked up on the assessment. For instance, impaired respiratory function will manifest itself in impaired mobility. The same was thought to apply to the other activities of living not included in the assessment.

The nursing assessment is not designed to enable a comprehensive assessment of every aspect of nursing. Rather it facilitates judgements about care needs by providing an initial assessment which alerts the nurse more quickly to the areas in which the patient requires care. Once these areas have been identified, a more detailed assessment can be undertaken if necessary. For instance, if the patients mobility is found to be impaired, the assessment would indicate the need to identify why mobility was impaired. If pain was a factor, then a pain assessment might be appropriate. Alternatively, if poor respiratory function was the cause of impaired mobility, then assessment of this function might be necessary.

The fact that practising nurses had been actively involved in the development of the assessment, and had continually tested and refined it by using it in practice, was considered to be important as it indicated that the

assessment had face validity. Face validity implies that the assessment is acceptable to practising nurses in that it meets their needs as practitioners. This was thought to be important, as it was recognised that if an assessment tool was regarded as a chore by the nurses who used it, no amount of statistical refinement would improve the accuracy with which it was used. If, on the other hand the dependency assessment formed part of the nursing assessment and was used as a basis for care planning, then nurses were more likely to be conscientious when using it.

This assessment was considered to be congruent with the methodological perspective adopted in this research, in that it was based on other research which had been undertaken by academic nurses (e.g. Norton et.al. 1975 and Rhys-Hearn 1977) and not operational researchers. It incorporated the social definition of health developed by Henderson (1966), but had been adapted and tested for practical use by practising nurses. Moreover, the assessment contained a scoring system which, it was felt, could be adapted to provide a method which could be used to measure patient dependency. It would therefore meet the requirements of the Delphi survey in providing a means of categorising patients according to their core nursing needs identified in the assessment. If established, these could be used to generate patient profiles from which a professional definition of nursing could be derived. Because the assessment seemed congruent with the aims of the research, a trial of the

assessment tool was undertaken in order to discover if it could be used for this purpose.

Using the Nursing Assessment to Identify Patient Dependency

A decision was taken to use three levels of dependency, as suggested by Barr (1967), who indicated that this was the minimum number of dependency categories that could be used to reflect nursing workload on a given ward. The use of the minimum number of categories was essential as it was recognised that each level of dependency required its own case study in the Delphi survey, and therefore the more categories used the bigger and more unwieldy the Delphi survey would have become. This would clearly have implications for the response rate.

The upper and lower scores for each level of dependency were identified in the following manner:-

Low dependency score 0 - 15. 0 is the minimum score a patient could obtain by scoring 0 for all the activities of living included in the assessment. 15 is the maximum a patient could obtain by scoring no more than 1 for any or all of the activities of living.

Medium dependency score 16 - 30. 16 is the minimum score a patient could obtain by scoring more than 1 for each of the activities of living. 30 is the maximum score the patient could obtain for scoring no more than 2 for each activity of living.

High dependency score 31 - 45. 31 is the minimum score a patient could obtain by scoring more than 2 for each activity of living. 45 is the maximum score a patient could obtain by scoring 3 for each activity of living.

A trial of the categories of dependency derived from this assessment tool was undertaken in order to discover if it could generate case studies for use in the Delphi survey. The trial was undertaken in the District General Hospital in which the researcher had worked as a sister prior to undertaking the research.

Two wards were included in the trial, a 30 bed general medical ward specialising in diseases of the heart and circulatory systems, and a 22 bed surgical ward specialising in diseases of the bowel and in breast cancer.

A two week period of observation by the researcher was undertaken on each ward. During this time the researcher used the nursing assessment to assess 44 patients, 24 on the surgical ward and 20 on the medical ward. Each patient was given a score for each of the activities of living included on the assessment. The score for each of the activities of living was totalled to identify the patients dependency level.

Table One gives the number of patients in each ward classified into dependency categories using the nursing assessment. 16 patients were found to be low dependency

patients, 9 surgical and 7 medical. 20 patients were found to be medium dependency patients, 14 surgical and 6 medical. 8 patients were found to be high dependency patients, 1 surgical and 7 medical.

TABLE ONE
CLASSIFICATION OF PATIENTS BY DEPENDENCY DURING THE TRIAL OF THE NURSING ASSESSMENT TOOL

WARD	DEPENDENCY CATEGORY			TOTAL
	HIGH	MEDIUM	LOW	
MEDICINE	7	6	7	20
SURGERY	1	14	9	24
TOTAL	8	20	16	44

As well as undertaking a nursing assessment of each patient, information was also recorded on the patient's diagnosis, medical treatment, and nursing care during the shift in which the assessment was carried out.

The reasons for collecting the above data on the 44 patients were two-fold. Firstly it was undertaken in order to determine whether the nursing assessment developed by Hunt (1982) could be used to classify patients according to dependency. Secondly, if it was found that the assessment could be used to determine patient dependency, then the data would form the basis for the development of the patient profiles to be used in the first round of the Delphi survey.

Previous manpower studies classified dependency levels according to the amount of nursing time each level required.

As timing was not being used in this research another method for differentiating between the nursing needs of patients in each group was required. The scoring system described above classified patients into three groups. It was recognised that to have internal validity the assessment tool must identify discrete nursing characteristics which applied to all the patients in one grouping, but not to patients in the other two groups. If a set of discrete characteristics could be developed from the data collected for patients in each group, then it was considered that, for the purposes of this research, the assessment tool could be adapted for use as a method of determining patient dependency. The identification of distinct nursing needs for each group of patients would provide a framework for developing the patient profiles required by the Delphi survey. Taken together, the profiles would cover the major nursing needs arising out of the assessment for each category of patient found on general wards.

A detailed analysis of the data was undertaken with this objective in mind. The data were broken down into the different activities found on the nursing assessment form. The characteristics of each patient given a particular score for each heading were grouped together under that heading. The data were then searched for characteristics which appeared to be common to some of the patients, but not found in other patients. As a result of this analysis the following characteristics emerged from the data.

It appeared that patient's who scored 2 or more for a majority of the headings included on the assessment shared the following characteristics:-

These patient's were found to lack any awareness of, or to be unable to communicate, their need to maintain activities essential to living. Moreover they were also found to lack the physical ability necessary to undertake these activities for themselves. In other words they were both physically and psychologically incapacitated. Disease processes which produced severe confusion, or rendered the patient unconscious and which also resulted in severe physical disability would give rise to patients who scored 2 or more in most of the headings on the assessment form.

Of the 8 patients classified as high dependency by the nursing assessment tool, 6 were either unconscious or extremely confused, with some degree of physical incapacity. The other two were only mildly confused and were at times able to communicate lucidly with the nursing staff, although this was not constant. They were both severely physically incapacitated.

An analysis of the patients falling into the other two dependency categories indicated that some were severely physically disabled, and others were extremely confused. However, none of the patients in the other two categories possessed nursing needs arising from both physical and psychological disability. Therefore, for the purpose of

developing the Delphi case studies, high dependency patients were characterised as both severely physically handicapped and severely psychologically incapacitated.

For patients who scored more than one 1 but less than 2 for a majority of the headings included in the assessment form the following characteristics emerged:-

These patients were characterised by moderate to severe temporary (i.e. following surgery) or permanent physical incapacity which made them dependent on nurses for obtaining the care necessary to maintain normal bodily functions in each or some of the activities of living. They were, however, able to communicate their need for such care to the nursing staff.

Of the 20 medium dependency patients identified in this research, 16 fitted this description exactly. The other four were all borderline cases and could have been incorporated into the high dependency category. One was a patient assessed on return to the ward following a general anaesthetic, and therefore the borderline result reflected the effects of the anaesthetic and was only temporary. She complied with the characteristics of the medium dependency group as soon as she recovered from the anaesthetic. The other three had retained all their physical dexterity, but each was extremely confused.

An analysis of the patients falling into the other two

categories indicated that none of them possessed physical disabilities which made them dependent on the nursing staff for physical care, and at the same time were able to lucidly express what their care needs were. For this reason, these characteristics were taken to reflect the needs of medium dependency patients.

For the patients that scored less than 1 for the majority of headings in the nursing assessment the following characteristics were identified:-

These patients were found not to be physically dependent on the nurse for any of the activities identified on the assessment form. Moreover, it was also found that they could take responsibility for maintaining their own activities of living, acting on the advice of the nursing staff if appropriate.

Of the 16 low dependency patients identified in this part of the research, 15 were found to conform with the above characteristics. The one patient in this category who did not conform to the above criteria was physically independent, however he required a complicated wound dressing to be undertaken daily by the nursing staff. Again these characteristics were found to be unique to the patients classified by the assessment as low dependency,and for this reason both physical and psychological autonomy were taken to characterise low dependency patients.

The above analysis gave rise to the identification of three

different levels of nursing intervention which reflected the predominant patient characteristics found in each group of patients. For high dependency patients it was recognised that the fact that these patients are unable to recognise or communicate their needs to nurses means that nurses not only have to give care, they also have to take responsibility for identifying the care known to be essential for maintaining normal bodily functions in each of the activities of living identified.

For medium dependency patients, however, while the nurse may still have to give the care, in most circumstances this care can be negotiated with the patient, who is able to lucidly express their own needs for care. Under these circumstances the care to be given and responsibility for maintaining activities of living is shared between the patient and the nurse. Low dependency patients are characterised by their independence from nursing staff for physical care, and by their ability to take full responsibility for that care.

The only patients who did not fit into any of these categories were mobile confused patients who tended to score high on some activities and low on others. The needs of these patients appeared to straddle the medium and high dependency categories. This did not present any problems for the survey, as their needs for each activity of living were incorporated into one or the other profile. It did, however, present a problem when the observation schedules, which were derived from the survey, were used on the ward to identify

the needs of these patients. For this reason, the method used to match the assessment to the observation schedules was adapted during the observation stage of the research (see Chapter Five).

The above procedure was designed to produce a framework for developing the Delphi survey. It does not, therefore, validate the nursing assessment as a tool for measuring dependency. It does, however, group the patients according to needs which reflect contemporary developments in nursing ideology. For instance, it promotes independence in medium dependency patients, who are physically, but not mentally impaired, by reinforcing active participation by the patient in their own care. For high dependency patients, however, who are unable to participate actively in their own care, it recognises that the nurse must adopt a different role. The reflection of developments in nursing ideology in the construction and categorisation of patients using this assessment, suggests that it has greater construct validity than tools which only reflect physical differences, and therefore produce groups of patients who may require very diverse approaches to nursing care.

DEVELOPING THE DELPHI SURVEY

As a result of the above analysis, three patient profiles were developed, reflecting the discrete characteristics of high, medium and low dependency patients described above.

The profiles are given in Appendix D, and were used as the basis of the first round of the survey. No diagnosis was given, as it was felt this would distract the participants from the aim of the survey, which was to identify the range of care thought appropriate to meet the dependency needs for each of the patients profiled.

The survey was designed to give the respondents as much scope as possible in identifying the care needs of the patients profiled. The only attempt at pre-determining the responses was in the characteristics given in the survey. Three A4 size pages were attached to each profile in an attempt to indicate the desired length of the response. For each profile, the nurse was asked to describe the care required by the patient described. The only other information collected was the reasons why this care was considered necessary. This was requested in order to ascertain the principles underlying the care identified by the nurse. It was hoped that this information would highlight the theoretical and ideological perspectives which were being used by the respondent. Consequently, each page was divided down the middle, the column on the left handside was headed "Required Nursing", the column on the right hand side was headed "Reason for Care Specified" (see Appendix D). Before undertaking this survey, a pilot study was carried out in order to ascertain whether nurses were able to provide the information requested.

Piloting the Delphi Survey

It was decided that participation in the survey should be directed at ward sisters/charge nurses, as they have direct responsibility for identifying and initiating patient care at a clinical level. A pilot of the survey was carried out in the District General Hospital used for the trial of the nursing assessment. 15 Sisters completed the pilot survey, 4 from medical wards, 4 from geriatric wards, and 7 from surgical wards. Although the sisters expressed some reservation about the lack of a diagnosis around which to organise the care, they were all able to complete the survey. The result of the pilot indicated that it was possible to use this format to identify the range of possible care for patients in each dependency grouping. It also indicated that asking for the reasons care was given was valuable in identifying the different nursing perspectives being used.

Obtaining a Sample

The Chief Nursing Officers in the 15 District Health Authorities (DHA) in the Region agreed to distribute letters to ward sisters/charge nurses in their own Districts asking them to participate in the survey. Chief Nursing Officers were asked to circulate a letter from the researcher containing information about the survey, and a form to be completed by the sister/charge nurse and returned to the researcher, indicating whether or not they wished to participate in the survey (Appendix H is a copy of the

letter and form circulated). All ward sisters/charge nurses working in each District were to be circulated, except those working in the following units.

Mental handicap, mental illness, paediatrics, accident and emergency, obstetrics/midwifery, operating theatres, out-patients, community services.

These units were excluded, as it was decided to restrict the research to learners undergoing general nurse training, and to identify their service contribution on general wards. The above units perform specialist functions, therefore the work content is specific to that unit. The learner training for the general part of the register will usually only be allocated to each of these units once, and therefore will be unfamiliar with the work to be undertaken. This is not the case on the general wards, as research by Roper (1976) demonstrates.

Unfortunately, it was not possible to obtain a list of the total number of ward sisters/charge nurses working in the selected wards throughout the Region, even using the computerised manpower systems available at the Region. This was why the above method of distribution was adopted. As a result of this exercise 229 forms were returned, 196 from ward sisters/charge nurses agreeing to participate, 33 from ward sisters/charge nurses declining participation. Out of 15 Health Districts only 14 were circulated as one Health District refused to distribute the letters on the grounds that the ward sisters/charge nurses in that District were

too busy to participate in what could become a lengthy and time consuming piece of research (Appendix I indicates the range of specialities in which the sisters/charge nurses who responded worked).

ROUND ONE OF THE DELPHI SURVEY

The 196 sisters/charge nurses who agreed to participate were sent the first survey to complete. (Details of the information sent to the participants is given in Appendix D). 113 completed the survey, which gave a response rate of 57%. As Oppenheim (1978) points out, questionnaires completed by mail usually have a poor response rate. As he suggests, the important point about a poor response rate is not the reduced size of the sample, which could be overcome, if this were important, by sending out more questionnaires, but the possibility of bias. Bias in quantitative research is introduced when the sample population does not represent the parent population from which it is derived. If this occurs, then the possibility of generalising from the sample population to the parent population is similarly reduced. However, in the case of this research no attempt was made to draw a representative sample in the first place. This would have required a very different sampling procedure. Instead, the aim was simply to develop criteria for observing nursing care from nurses who were also practitioners.

The sampling procedure, described above, does not give rise to a representative sample of nurses, therefore the results cannot be said to be representative of the views of

practising nurses. Instead what is claimed is that the observation schedules produced from the Delphi survey were derived from qualified nurses who were involved in practice; consequently they were grounded in their interpretation of nursing care. While they are clearly idealised accounts of nursing, they are not derived solely from academic literature, which may well be divorced from the realities of practice.

Attempts were made to increase the response rate by sending out follow up letters and further copies of the survey. However as many of the participants pointed out, it took two to three hours to complete the survey (some participants indicated it took a lot longer), many indicated they completed it in their own time. Therefore a high degree of motivation was required and this probably contributed to the response rate. Certainly the amount of detail given by respondents in the survey indicated that a considerable amount of time was devoted to it.

Analysis of Stage One of the Delphi Survey

The data were analysed using ledgers usually used for accountancy. Each respondent was given a coded number. The analysis proceeded by organising the data under a series of headings which reflected activities of living. Each activity of living was given a separate section of the ledger. Any nursing care mentioned for the patient related to that activity of living was written down under the appropriate

heading. For instance, under the heading nutrition/hydration for the medium dependency patient, the following categories were abstracted from the survey:-

Assess nutritional state; monitor food intake; supervise meals; find out what the patient eats at home; cut up food etc.

This is a small sample of the care needs identified for this patient for nutrition/hydration. For the purposes of checking the data, the respondent's number was put in a line at the top of the page. Any categories of care mentioned by the respondent for that activity of living, that had already been mentioned by previous respondents was simply ticked under that respondents number. Any further categories of care for that activity of living not mentioned by earlier respondents was added to the list and ticked for that respondent. In this way a composite picture of the care needs identified by respondents for each activity of living for each patient profiled was developed.

In the survey the respondents were asked to identify the care needs of the patient profiled and to write their response in the column headed "Required Nursing". They were also asked to give the reasons why each aspect of care was considered necessary in the column headed "Reasons for Care Specified" (see Appendix D). In the analysis an attempt was made to differentiate between these two responses for each activity of living. The reasons for care given were entered in capital letters in the ledger, the required nursing

associated with the reason was entered in lower case under the allied reason. Some respondents did not supply reasons for care given in every case. These data were separately classified.

Interpretation of Round One of the Delphi Survey

A major finding arising out of the analysis of these data were the complex, and, in many ways, incompatible nature of the responses given. Not only did many of the replies given by one participant contradict the answers given by another respondent, but sometimes incompatible responses were given for the same patient by the same respondent. If we take patient one, the high dependency patient, it is clear that the care of this patient presents a dilemma for the nursing staff, which was recognised by a number of the respondents. For instance the following comments are abstracted from the survey.

"Turn patient. Difficult if needs to sit upright because of chest condition, big danger of sacral sores".

"Positioning a breathless patient is often very difficult exacerbated by a chest infection"

"Nurse in an upright position to reduce agitation may create problems with pressure area care".

"Turn the patient 2 hourly onto as many different positions as possible without impairing respiratory function".

This suggests that considerable difficulties appear to surround the positioning of this patient which were recognised as dilemmas by the nurses responding to the

survey. Table Two gives the responses that were categorised under the heading "prevention of pressure sores" in relation to positioning the patient. This can be contrasted with the

TABLE TWO

NURSING ACTIONS IDENTIFIED IN THE SURVEY TO PREVENT PRESSURE SORES

RESPONSES GIVEN	No. OF RESPONDENTS GIVING THAT RESPONSE
Turn Patient	61
Change position	48
2 hourly or less	84
2 - 4 hourly	4
Depends on severity	7
regularly/frequently	13
Sit out in a chair	24

care required to maintain respiratory functioning in this patient. Here, the physical positioning of the patient was also considered to be important. Table Three gives the responses categorised under the heading of "respiration/position of patient".

Table Two indicates that most of the respondents identified the need to turn or move the patient regularly. The analysis of the "reasons for care given" indicates that 92 respondents explicitly stated the need to prevent pressure sore development, while others simply stated that this aspect of care should be given. Most of the respondents suggested this care should be carried out at least 2 hourly, though a number suggested that a regime based on an individual assessment of the patient was more appropriate.

TABLE THREE
NURSING ACTIONS IDENTIFIED IN THE SURVEY
TO POSITION THE BREATHLESS PATIENT

RESPONSES GIVEN	No. OF RESPONDENTS GIVING THAT RESPONSE
Facilitate chest expansion	49
Prevent chest infection	11
when positioning patient	11
Nurse in an upright position	47
In a bed	15
In a chair	13

However, as Table Three suggests, this aspect of the patients care clearly raises problems for other facets of their care, in particular maintaining respiratory functioning. Some of the respondents were aware of this dilemma and raised it as an issue. Others incorporated both aims of care within a single response, while others failed to elaborate on the principle of turning and therefore did not attempt to operationalise it within the context of the care needed by this patient.

Agitation and restlessness in the patient was another area which raised similar problems. Here 59 respondents suggested that a patients agitation may be due to pain, and therefore analgesia should be given. However, as one respondent pointed out, pain should be relieved "without affecting the respiratory or cardio-vascular system, or increasing the risk of constipation", all of which are potential side effects of analgesic drugs. Other responses to the problem of agitation included isolating the patient, as a number of

respondents suggested their behaviour can be very disturbing for other patients. However, as some of the participants pointed out, isolation may well increase the degree of agitation experienced by these patients.

Similar contradictions were found under the heading of urinary elimination. Table Four gives the aims of care identified under this heading for the high dependency patient. These were derived from the analysis of "reasons for care given".

TABLE FOUR

AIMS OF CARE FOR PATIENTS WITH URINARY INCONTINENCE

AIMS OF CARE	No. of RESPONDENTS GIVING THAT RESPONSE
Identify elimination pattern	6
Retrain bladder	26
Prevent pressure sores	51
Prevent incontinence	58
Monitor fluid output	21

Table Four indicates that only 26 respondents specifically identified retraining the bladder as an aim of nursing care for this patient, while 51 respondents explicitly identified the link between urinary incontinence and pressure sore development. However, in the analysis of the care needs of this patient given in the column headed "required nursing", 54 respondents suggested the need to offer this patient toilet facilities two hourly or less, either as part of a bladder retraining programme, or to lessen the incidence of urinary incontinence, or both. 95 respondents suggested that

this patient may need to be catheterised. 27 respondents suggested that this was the preferred course of action, while 31 said that catheterisation should only be used as a last resort when all other approaches to this aspect of care had failed. 22 respondents were very ambiguous about the use of catheterisation in this patient, suggesting that ideally it was not the preferred course of action, but acknowledging from experience that other methods of controlling incontinence usually did not work. As a result, they advocated catheterisation as an appropriate, though not preferred, course of action.

Finally, the aim, "monitor fluid output", introduced into this aspect of nursing the investigative and diagnostic components of care. 20 respondents suggested that catheterisation would facilitate the measurement of urine, 5 suggested that it would enable the urine to be tested, 1 suggested the importance of this if the patient was a diabetic, and 15 indicated the need to test for urinary tract infection by taking a sterile specimen of urine, a procedure that is difficult if the patient is incontinent.

What is immediately apparent from the figures given above, is that they do not add up. 95 respondents suggested the need to catheterise the patient, but only 80 elaborated on this (27 + 31 + 22 = 80). Throughout the analysis of the Delphi survey this manifested itself as a real problem. The open-ended nature of the survey meant that respondents were

free to write as much or as little as they chose. Some respondents wrote only a page for each patient described, while others added several pages. One respondent completely abandoned the format given, and sent several closely typed pages for each patient. Clearly, therefore, the amount of detail given varied considerably. Some respondents simply wrote "catheterise the patient" and did not elaborate or give the reasons why. Others suggested a whole range of strategies that could be adopted and gave reasons for each strategy. Consequently, a lot of double and treble counting is involved in the analysis of the data. This arose out of the open-ended nature of the survey, and the method of analysis. Insufficient data were provided to undertake any other form of analysis. Moreover, to do so suggests that coherent and unambiguous responses were possible, and even desirable. However, as the above discussion suggests, this is not the case in practice, and this should therefore be reflected in the research.

Discussion of the Results of Round One of the Delphi Survey

The above analysis highlights the ambiguity and uncertainty that currently surrounds the implementation of basic care needs. It reinforces the suggestion made in the first chapter, that basic care is not the unskilled and unproblematic phenomena it is frequently taken to be. Instead, it suggests that basic care is fraught with contradictions. Nursing care actions designed to promote an identified aim of care, may, if implemented, undermine other

aims of care for the same or different activities of living. Moreover, the results suggested that the respondents who took part in this survey were not unaware of the ambiguous nature of basic care. Many of the respondents wrote a number of pages agonising over the dilemmas raised by the case studies presented. But as the data on catheterisation suggest, they frequently advocated pragmatic solutions to the problems they raised.

This finding reinforces the problematic nature of professional practice described by Schon (1983), and by Robinson (1987), discussed in Chapter One. They focus on the difficulties of operationalising research derived from a positivist perspective in the practice environment. The sisters and charge nurses who took part in this survey were clearly aware of the dilemmas this can raise in practice. Therefore, it is possible to suggest that failure to observe a prescriptive nursing action derived from a particular ideological or research perspective on nursing, does not mean that that the nurses do not know about or are unaware of the need for that action. As the above discussion indicates it could instead mean that the nurses have simply failed to identify how to operationalise this aspect of care in practice, particularly if it contradicts other aims which they also consider to be important. As suggested in Chapter Two this then becomes the problem for both the researcher and the practitioner.

ROUND TWO OF THE DELPHI SURVEY

The original aim of the Delphi survey was to produce a consensus from practising nurses on the nursing needs of the patients profiled. The second round of the Delphi survey should therefore have fed the total results of the first round back to the participants who would be asked to prioritise the nursing care needs of the patients. Further rounds are undertaken until a consensus is achieved about what the priorities are. However as the analysis of the first round of the survey proceeded, this exercise began to appear increasingly spurious in the context of this research.

Conceptual Problems with the Development of a Consensus

The first round of the Delphi survey indicated that observation schedules that incorporated actual nursing actions were likely to be very unwieldy. For instance, the aims of care for urinary elimination, given above in Table Four, represented five rows of analysis under this heading for patient one. For these aims of care, 36 different nursing care actions were given. Five further aims of care for catheterised patients only were given; these were:- prevent urinary tract infection; maintain bladder tone; prevent trauma to the urether; prevent blocked catheter; prevent urine reflux into the bladder. These five aims gave rise to 39 different care categories or suggestions as to how these aims could be operationalised. This suggests that a greater degree of consensus existed about the aims of care

which were relatively unproblematic compared with the difficulties of operationalising these aims in practice. Moreover the relatively large number of actions identified not only reflected different approaches to nursing identified by different respondents, but also reflected a recognition on the part of the respondents of the need to adapt care to the specific needs of the patient. Frequently therefore a respondent would identify a number of different ways in which a particular aim could be met. This suggests that local circumstances would determine which particular strategy was appropriate.

It became apparent that concentrating on the development of observation schedules which reflected descriptions of nursing action was not particularly useful as this would have produced descriptive procedures for each dependency level profiled, reflecting for instance, mouth care, turning, nutrition, and mobilising a patient. This implies that the nursing role resembles that of a technician charged with implementing learnt procedures in appropriate circumstances. As Schon (1983) points out, the domination of knowledge by technical rationality has failed to recognise the need to adapt that knowledge to the peculiar and specific circumstances of practice. It is the ability to recognise the uncertainty which is derived from the application of technical knowledge to novel situations, and the ability to adapt practice to accommodate this uncertainty, which Schon suggests distinguishes professional

knowledge from other forms of knowledge. Therefore, the attempt to produce a definition of nursing practice which focused on a description of nursing action, was abandoned as methodologically tortuous and theoretically unsound.

However, the responses given under the heading "reasons for care specified" appeared more appropriate to the development of a professional definition of nursing. These responses focused on aims of care and not on nursing actions. Therefore, they provided a framework for practice, but did not prescribe nursing behaviour. Instead, once the aim was identified, the nurses responsible for caring for the patient could identify how it could be met, taking account of the patients own wishes, specific patient problems and local ward circumstances. This appeared to provide a framework for analysing the contribution made to care by learners within a professional definition of nursing, which also took account of the local context of care. It consequently upheld the major tenet of qualitative research, while at the same time overcoming the unskilled definition of basic care, which has characterised traditional approaches to manpower research. Consequently, a decision was taken to focus on the aims of care, as these appeared to meet the criteria for a professional definition of nursing developed in Chapter One.

Conceptual Problems with the Development of a Prioritised Framework For Observing Care

According to Linstone and Turoff (1975) second and subsequent rounds of the Delphi survey aim to produce a consensus by asking the respondents to prioritise the results of the previous round. Clearly this process could have been pursued with the aims of care. These could have been fed back to the respondents and priorities developed for each patient profiled, which could lead ultimately to a valid professional definition of nursing aims for each level of dependency.

Continuing the Delphi survey according to the above process would clearly have reduced the number of variables included on the observation schedule, by eliminating aims of care which only one or two respondents suggested. However such an exercise began to appear increasingly spurious in the context of this research, as yet again it would imply that the consensus produced had some sort of objective validity which could be used to inform action. While it is probable that the consensus produced in the Delphi survey would reflect the priorities of care identified by the nurses in the ward situation, a problem arises if different priorities were identified in the ward for a specific patient. Eliminating aims of care via prioritising, and only including in the observation schedules aims around which a consensus was developed, implied that the consensus definition of care was more valid than aims of care identified by the nurses on the ward or by the minority

respondents in the survey. Given that the sample was not a representative sample in the first place, this position appeared to be untenable.

The emphasis given within the Delphi survey to prioritising the responses began, therefore, to appear as totally incongruent with the theoretical perspective adopted by this research. Prioritising implies the need to identify which aspects of care are to be emphasised or given greater importance. As the results of the first round, given above, suggested, this in itself can be a difficult exercise, involving the need to mediate between nursing actions which facilitate one aim of care, but undermine another. This suggests that priorities can only be determined within the context of practice. To attempt to develop prioritised schedules appeared, therefore, to be a meaningless exercise, as it is not at all clear what relationship, if any, they would have to observed practice.

An exploration of how nurses resolved the problems of prioritising nursing care appeared to be more appropriately undertaken during the observation stage of the research, where the actual context of care could be incorporated into the analysis. For this reason a decision was taken not to ask participants to prioritise the data. Instead, emphasis was given to the development of comprehensive observation schedules which incorporated the full range of aims of care identified by all the respondents. While overcoming the problem of identifying the relationship between the

schedules and observed practice, this created other methodological problems. Primarily it produced large and unwieldy schedules (see Appendix E) which had implications for the time spent by nurses reading through the schedules in order to identify the aims of care for a specific patient. This problem is discussed more fully in Chapter Five.

Given these problems, it is arguable that a second round of the survey was not really necessary, as sufficient information was obtained from the first round to develop observation schedules derived from the responses given under the heading "reasons for care specified". However, the responses to the first survey produced a mass of descriptive data. In any attempt at content analysis in open-ended surveys there is always the difficulty of accurately classifying the data. Different nuances of meaning shade the distinctions between the different categories, making it difficult to identify the category into which a particular response should go, and at what point different wordings of a similar response give rise to a different inflection or meaning. Judgements had to be and were made during the course of the content analysis. One method of reducing the element of misrepresentation by wrongly categorising data is to ask someone else to classify a sample of the data independently, and then to ascertain inter-rater reliability. The primary reason this was not done was because at at a pragmatic level there was no-one else

available to do this, as it was an extremely time consuming exercise. Moreover, this again presupposes that the data can be objectively classified, whereas these data were distinguished by uncertainty and ambiguity expressed by the respondents themselves.

The difficulties experienced in classifying the data in the first round, coupled with the change in orientation of the survey away from nursing action to nursing aims, suggested that a second round might be useful to validate the findings of the first round. This was not used to generate a consensus but simply to check that an adequate analysis of the original data had been undertaken. It therefore did not conform to the traditional Delphi technique. Instead, it resembled a process of feeding back to the respondents the results of the first round, in order to ascertain whether or not the researcher's interpretation of their responses reflected the meanings they had attached to their initial statements. In many ways the second round represented an attempt to demonstrate congruity between the researcher's analysis of the responses given in the first round of the survey, and the interpretation intended by the respondents. It therefore corresponds to traditional methods of validating qualitative research suggested by Hewitt (1979) and Halfpenny (1979); namely to validate findings by demonstrating congruity between the sociologist's account and that given by the actors, or in this case the respondents.

In accordance with the analysis given above, the second round of the Delphi survey focused not on nursing actions, but on the aims of care identified in the first round of the survey. Aims of care were abstracted from the data for each activity of living included in the responses, for each patient profiled. All the aims identified in the survey were included in the second round, even aims which had only been suggested by one or two respondents. The aims of care were listed under the headings used in the analysis. Two boxes were put beside each aim, one headed "necessary" and the other headed "not necessary". The respondents were asked to tick whether or not they thought the aim of care was "necessary" or "not necessary" for the patient profiled. A copy of each profile was sent out with the second survey for the respondents to refer to. The format and subsequent responses to this survey are given in Appendix J.

The survey was circulated to the 113 participants who took part in the first round of the survey. Of the 113 participants 100 returned the completed second round survey, a response rate of 88%. This is a relatively high response rate for a postal questionnaire and considered to be acceptable for the purposes of this research.

Appendix J gives the results of the second round. It indicates that most of the respondents agreed with most of the aims of care abstracted from the first round of the survey. Altogether 377 different aims of care were identified in the survey. Of these 377, 327 aims of care

were considered necessary by over 80% of the respondents. This suggests that the original content analysis of the first round of the survey accurately reflected the data given. It suggests, therefore, that the observation schedules which are derived from the second round of the survey, are a valid adaptation of the data obtained in the first survey.

These results indicate a high level of consensus among the participants about the aims of care for each of the three patients profiled. However, it is probable that this was achieved because the respondents were not asked to prioritise the results of the first round of the survey, and therefore did not have to make choices about the relative merits of each of the aims identified. As a result, most of the respondents indicated that all the aims of care given were necessary, even though it is possible to identify clear contradictions between many of the aims given for the same patient.

DISCUSSION OF THE FINDINGS OF THE DELPHI SURVEY

Reading through the aims of care given in the second survey (Appendix J), it is apparent that many of the headings could be further classified into more abstract categories. For instance, some of the aims appear to relate to the concept of promoting autonomy and independence in the patient. Table Five gives the aims of care for patient two which appear to relate to this concept. Most of the aims seem to reflect the

TABLE FIVE
AIMS OF CARE WHICH PROMOTE AUTONOMY FOR MEDIUM DEPENDENCY PATIENTS

AIMS OF CARE FOR EACH ACTIVITY OF LIVING	% OF RESPONDENTS AGREEING WITH AIM
PLANNING	
Involve patient in assessment of care needs	95
Involve patient in planning care	94
Involve patient in the evaluation of progress	96
Aim to promote independence in each aspect of care	99
Only involve relatives/carers in the assessment, planning and evaluation of care if patient agrees to their involvement	72
MOBILITY	
Aim to obtain maximum walking capacity	96
DRESSING	
Enable patient to become independent in this aspect of care	96
Develop training programme for dressing with patient	93
HYGIENE	
Enable patient to take decisions about care needs	96
Enable patient to become independent in this aspect of care	97
Enable patient to control hygiene:-	
routine	94
standards	95
FEEDING	
Develop training programme to promote independent feeding with patient	81
Respect patients diet choices	99
Enable patient to eat at times of own choice	58
COMMUNICATION	
Discuss nursing care plan with patient	95
Inform patient of:-	
medical plan	93
diagnosis	82
progress	97
investigations	95
results	91
likely outcomes of care	95
SOCIABILITY	
Promote patient control over illness	94
PAIN CONTROL	
Discuss pain control with patient	97
Use any method of pain control identified only if the patient agrees	88
Inform patient of any side effects of analgesia	87
RELATIVES/CARERS	
Only give information to relatives/carers if patient agrees	72
Identify ways of involving relatives/carers in care of patient - only if patient agrees to their participation	87

definition of autonomy and independence put forward by Seedhouse (1986), discussed in the first chapter. In other words, most of the aims recognise the need to involve the patient in planning their own care, and recognise the need to respect the patient's choices about care. These aims, however, can be contrasted with those which appear to relate to therapeutic rehabilitation. These are given for patient two in Table Six. Here the interpretation given to independence appears more to reflect that of the medical model, in that it focuses on functional independence and greater emphasis is given to the need for therapy if this goal is to be achieved.

At an abstract level these two aims need not conflict, it is quite possible, as Seedhouse suggests, to let the patient set their own rehabilitation goals. For them to do so, however, and for this to be acceptable, appears to require a fundamental change in the relationship between patients and their professional carers. If, as the work of Henderson (1966) and Bower and Bevis (1979) implies, the nurse possesses special expertise which enables her to bring about adaptive change in the individual so as to promote health, then clearly it is the nurse, and not the patient who is setting the goals.

This point is particularly well illustrated in the aim of educating the patient about a healthy diet, and the aim of respecting a patient's diet choices. If Seedhouse's (1986) definition of the wellness model is applied to these two

TABLE SIX

AIMS OF CARE WHICH PROMOTE REHABILITATION FOR MEDIUM DEPENDENCY PATIENTS

AIMS OF CARE FOR EACH ACTIVITY OF LIVING	% OF RESPONDENTS AGREEING WITH AIM
PLANNING	
Assess the nursing needs of the patient:-	78
on admission	96
at regular stated intervals	82
as condition changes	93
Identify methods of promoting independence in each aspect of care	97
Plan nursing care to be given	99
Evaluate progress	96
MOBILITY	
Assess need for physiotherapy referral	98
Carry out physiotherapy regime	95
Assess need for occupational therapy referral	99
Carry out occupational therapy regime	95
DRESSING	
Assess need for occupational therapy referral	96
Develop training programme for dressing:- with occupational therapist	92
HYGIENE	
Assess need for occupational therapy referral	95
Carry out occupational therapy regime	92
Identify aids required	94
Teach use of aids	94
FEEDING	
Assess need for occupational therapy referral	77
Develop training programme to promote independent feeding - with occupational therapist	64
Evaluate progress regularly	88
Identify aids required	79
Assess need for referral to dietitian	96
Educate patient about a healthy diet	95
COMMUNICATION	
Reduce anxiety levels	100
Reduce frustration	100
SOCIABILITY	
Gain co-operation	100
REST	
Identify any difficulties with sleeping	100
Discuss difficulties with patient	100
Identify means of overcoming difficulties	100
PAIN CONTROL	
Aim to control pain	91
Aim to prevent pain	90
RELATIVES/CARERS	
Identify ways of involving relatives/carers in care of patient	98

goals, then they are in fact compatible, as the expected outcome would not be a change in diet but a change in knowledge. If, however, the definition of wellness developed by Bower and Bevis (1979) and by Henderson (1966) is applied, then one would expect to see a change in actual diet, which means that the goal has in fact been determined by the nurse and not the patient.

This analysis suggests that the contradictory definitions of independence and autonomy embraced by the different models only become apparent in situations where the patients goals, for whatever reason, do not coincide with those of the nurse. This reinforces the arbitrary nature of priorities determined in the abstract, as suggested earlier, and highlights the importance of determining priorities in the context of the situation in which they are to be implemented.

The above discussion attempts to link the aims of care which emerged from the survey to the more theoretical debate about the goal of health care and the role of professionals given in the first chapter. What clearly emerges from the survey is that the ward sisters and charge nurses who took part, and who gave substantive support to the aims of care (see Appendix J) identified in the second round of the survey, are not unaware of the different philosophical perspectives on health care discussed in the first chapter. In fact, their responses to the survey suggests they have been profoundly influenced by this debate. The results

appear to refute suggestions that nurses do not read literature on nursing, are unaware of recent developments in nursing, and require further education (Hunt 1981, Wells 1983). It reinforces the suggestion, made in Chapter Two that the problem for both nurse researchers and nurse practitioners is how to operationalise these concepts in practice.

CONCLUSION

The above discussion indicates that the aims of care given in the survey can be operationalised in a number of different ways. Independence, for instance, can be promoted by applying the medical model of health, a nursing model of health, and by utilising the concept of the wellness model described by Seedhouse (1986). Each interpretation can give rise to very different types of action. This suggests that if, during the course of observation, researchers discover that nurses do not implement goals which the researcher has identified as appropriate, then it is simplistic to assume that this is because the nurses do not know about them. Instead, they may have interpreted the goal differently, or been unable to operationalise, the goal or given greater priority to other aims of care.

The emergence of a variety of competing definitions of nursing from the Delphi data gave rise to the first working hypothesis or research proposition namely; that nursing is currently characterised by a lack of consensus about the

aims of care, and that nurses in practise must mediate between these aims in the implementation of care. This proposition was used as the starting point for the analysis of the observational data. It provided a framework for categorising these data, as it raised questions about where the locus of control for resolving the dilemmas highlighted in the Delphi survey, is situated on a ward. It suggested that the observational data could be classified according to whether control over decisions about aspects of care are located primarily with the patient, or with the nursing staff. The data on the nursing staff could be further classified according to whether control over the decision making agenda was located primarily with the qualified staff or with the learners. This enables the care given by learners to be categorised according to the aims of care it promotes. This in turn can be linked to the wider debate about the nature of individualised care, given in the first chapter.

This appeared therefore, to provide a framework for analysing the contribution made to patient care by learners. As discussed in Chapter One, the question surrounding the grade mix of staff required to implement individualised care, has not been explored in either the literature on the nursing process, or in the literature on nurse manpower planning. This forms the focus of the next chapter, which describes the staffing structures found on each of the three wards. It examines the way in which each ward had attempted

to introduce a system of patient allocation that promoted continuity of care to patients, and discusses the methods of work allocation observed within the prevailing staffing structure.

Chapter Four

The Effects of Learner Nurse Allocation on the Organisation of Nursing Care

Introduction

This chapter introduces the research district and the research wards. It describes the staffing levels and mix of grades of staff found on each ward and sets the staffing structures observed within their historical context. It goes onto describe the effects of the allocation of learners on the availability of nurses to work on the wards. Finally, it looks at the degree of continuity in the allocation of nurses to patients achieved on each of the three wards.

THE RESEARCH DISTRICT

A description of the research District is given in Appendix F. Within the District, systems of patient allocation had been introduced as the method of work organisation on all training wards. The nursing process was gradually being introduced as the method for planning patient care. However it had not been completely established on any of the training wards at the time of the research. Ideally the observation stage of the research should have been undertaken on wards using the nursing process, as this is thought to facilitate a more individualised approach to care giving. However, at the time the observation was being organised, the Regional Nursing Process Group (which is composed of Nursing Process co-ordinators from each DHA in

the Regional Health Authority which sponsored the research), suggested that the nursing process was not fully operational in any of the DHA's in the Region. Consequently, the same problem would have been encountered in other Districts. For this reason a decision was taken to continue with the research in this DHA.

The Selection of the Research Wards

Within the DHA the following criteria were used for selecting the wards used in the research.

1.The ward must be a general nurse training ward to which both student and pupil nurses at all stages of training are regularly allocated.

2.The learners must make up part of the staffing establishment of the ward, ie., they were not supernumerary.

3.The wards must reflect a variety of different clinical specialities, as it was not intended that the research should focus on the contribution made by learners to one speciality, instead it was aimed at a much more generalised level of analysis. This might be difficult to achieve if the wards were derived from the same speciality.

4.As far as possible the wards were general wards and not specialist units, as it was felt that it was on general wards that learners make their biggest contribution to care. A decision, based primarily on the time that was available, was made to undertake observation on three wards. As a

consequence of the above criteria three wards were selected for observation:-

1.A long-stay geriatric ward.
2.A general medical ward.
3.A gynaecology ward.

The Long Stay Geriatric Ward

This ward was selected as, although it is a speciality, it is an area which demands a considerable amount of basic nursing care and as previous research (Moores and Moult 1979) indicates, learners do make a substantial contribution to basic care because it is usually regarded as unskilled. Therefore, the fourth criteria was not thought to apply to this ward even though within the nursing syllabus it is described as a specialist area.

The selection of a long stay geriatric ward was perhaps the most arbitrary of the three wards used. The geriatric wards were situated in an ancillary hospital on the outskirts of the town. This hospital was orientated towards the care of the elderly. It had 222 beds plus a day hospital. Any one of the wards at this hospital to which learners were allocated would probably have been suitable for the purposes of this research. The Nursing Officer responsible for care of the elderly in the District was approached and she organised access to one of the wards. It is recognised that this situation is less than satisfactory as nursing officers may have their own reasons for wanting research undertaken on particular wards, but the hierarchical management structure

in nursing makes other forms of access difficult. The ward sister was approached and after a lengthy discussion agreed to participate in the research. Her major concern was that the research should not criticise the nursing care on the ward without appreciating the circumstances under which it was given. As the research was designed to focus not just on the provision of care, but also on the context both structural and professional, in which it was undertaken, it was possible to reassure her on this point.

Patients were admitted to the ward following assessment in a rehabilitation ward. Most of the patients were assessed as requiring long term nursing care (see Appendix M). As a result the ward had a relatively low turnover of patients. Hospital Activity Analysis data (HAA) indicate that for the year 1/10/83 to 30/9/84 the average length of stay on the ward was 125.8 days. During that period there were 99 deaths and discharges from the ward. HAA data collected for the period of observation (18/6/84 to 3/8/84) indicate that the average length of stay for this period was 258.7 days and there were 6 deaths and discharges during this period. Percentage occupancy of beds during the period of observation was 91.7%. This can be compared with the percentage occupancy for the previous year which was 94.2%. A plan of the ward and a description of the support services is given in Appendix F.

The Medical Ward

The medical ward was situated in the new District General

Hospital (DGH). This hospital had been open about 9 months at the time the research was conducted. The ward was chosen because it was the only medical ward to have transferred to the new DGH; all the other medical wards were still at their original site and were to be transferred when the second phase of the building was completed. The Accident and Emergency Department and Coronary Care Unit for the District had also been transferred to the new DGH. Consequently, all medical admissions through Accident and Emergency and transfers from Coronary Care went to this ward. The other medical wards in the District also took emergency admissions on referral direct from General Practitioners. The ward was chosen because it was the only medical ward in the District to accept admissions direct from the Accident and Emergency Department. The Sister was approached by the researcher and agreed to participate in the research. A description of the ward is given in Appendix F.

As this was only medical ward at the DGH it experienced a relatively high turnover of patients. HAA data collected since the ward opened on 1/11/83 to the period of observation 30/9/84 (total 11 months), indicate that the average length of stay for this ward was 6.1 days. The turnover interval for this period was 1.1 days and the percentage bed occupancy during this period was 85.1%. There were 1313 deaths and discharges from this ward during the 11 month period.

For the period of observation (27/8/84 to 10/10/84) HAA data indicate that the average length of stay was 5.1 days. The turnover interval was 0.6 days and the percentage bed occupancy was 89.6%. There were 221 deaths and discharges from this ward during the period of observation.

The Gynaecology Ward

All surgical wards were located at the new DGH. Initially access to a general surgical ward was negotiated and agreed by the sister. However, in the intervening period, the allocation of first year learners to general surgery was stopped, and consequently this ward no longer met the criteria for inclusion in the research, and an alternative surgical ward had to be found. Two types of ward were available, orthopaedics and gynaecology. The patterns of admission and discharge on the gynaecology ward were considered to better reflect the patterns of work found on the general surgical wards. For this reason, the gynaecology ward was chosen. The sister was approached and she readily agreed to take part in the research. A description of this ward is given in Appendix F.

HAA data collected on the gynaecology ward for the 11 month period since the ward had opened to the observation (1/11/83 to 30/9/84) indicate that on this ward the average length of stay was 3.6 days. The turnover interval during this period was 0.7 days and the percentage bed occupancy was 84.1%. During the 11 month period there were 1569 deaths and discharges from this ward. HAA data for the period of

observation (15/10/84 to 23/11/84) indicate that during this period the average length of stay was 3.2 days. The turnover interval was 0.9 days and the percentage bed occupancy was 78.2%. There were 214 deaths and discharges from this ward during the period of observation.

NURSE STAFFING ESTABLISHMENTS ON THE RESEARCH WARDS

Nursing services in the research district were divided into care groups each with its own line management and budget. The three wards observed during the research were managed under two different care groups. The geriatric and medical wards were managed under the Acute and Elderly care group, while the gynaecology ward was managed under the maternity services.

At the time of the research the NR3 formula (Nurse Ratio 3 see Appendix B) was used by the RHA to determine staffing establishments at ward level (SETRHA 1981). NR3 is derived from a formula produced by the Ministry of Health (1965) for calculating the Revenue Consequences of Capital Schemes (RCCS formula). The original formula was based on the analysis of staffing levels in a number of hospitals where the care was "thought to be good". It appears that no criteria for identifying good care were ever published. The number of beds and the number of nursing hours for each speciality in these hospitals were calculated. The RCCS formula was derived by dividing the number of nursing hours into the number of beds for each speciality. This produced a

ratio of nurses to beds for each speciality. To this figure a percentage weighting for sickness and absence and for teaching were added.

In SETRHA this ratio has been updated. The percentage for sickness and absence had been increased and incorporated an allowance for annual leave. The percentage allowance for teaching had also been increased. A further percentage allowance was introduced following the introduction of the 37½hour week. Weighting is also given for wards of up to five beds and between five to ten beds in size, as wards of this size were thought to generate an extra demand for nursing staff. The ratio of nurses to beds in each speciality produced as a result of this formula is given in Appendix B. This formula formed the basis for determining staffing establishments in each clinical speciality in SETRHA.

The nursing division at SETRHA recognise that the NR3 formula provides only a crude guide to staffing levels . It stressed in the planning guidelines that it must be "interpreted with caution" (SETRHA 1981).

One of the major problems confronting an analysis of nurse manpower is actually getting hold of accurate figures. A ward can have a number of different "official" staffing levels depending on the source of the information used. The current staffing establishments in the Acute and Elderly care group are primarily historically determined. Some

attempt had been made to identify appropriate staffing levels by the commissioning officers of the new hospital in 1981/1982. Here it was agreed that Acute and Elderly Services should be staffed at NR3 + 16%. The 16% covers for annual leave, sickness/absence, maternity leave and staff development. Maternity Services should be staffed at NR3 + 22% (for annual leave and sickness/absence) + 6.5% (for the introduction of the 37½ hour week). The maternity staffing level was in line with the contemporary Regional Health Authority guidelines on NR3. The current nursing management had only been in post since the abolition of the Area Health Authorities in 1982 and therefore were unable to provide any information on why this discrepancy in staffing levels existed.

NR3 therefore provided one method for determining staffing levels within this District. However, budgets also appeared to impinge on staffing levels. As the analysis given below demonstrates a discrepancy can exist between the staffing levels identified by NR3 and the actual money available to meet these levels. Consequently it is possible to have both an official shortage of nurses, and nurses not being found posts at the end of their training. This situation arises if the budget falls short of the staffing levels determined by an official formula such as NR3. Finally, as the analysis of the staffing levels found on the geriatric ward given below suggests, the ability to recruit staff can be a final factor influencing the actual staffing establishment found on a

ward.

For the purposes of this research the "official" staffing establishment used was that given by the nursing officers in charge of the various wards, in each case they included a percentage of learners. Preliminary discussions with the sisters at the start of the research revealed that the actual allocation of learners to their wards fluctuated substantially. Moreover, the geriatric ward had particular problems with recruitment and its permanent in-post staffing levels had never equalled the official staffing level. For this reason a distinction is made, in the analysis of the staffing structure, between actual and official staffing levels, as clearly the discrepancies have implications for the organisation of care on the ward. The "in-post" figures used in this research reflect the actual staffing levels found on the ward during the period of observation.

Discussions with the sisters and the figures they presented from the learner nurse allocation office, suggested that fluctuations in the allocation of learners to each ward was a particular problem. As this was also a key aspect of the research, it was felt that this should be investigated over a longer period of time than the two to three month observation on each ward. Therefore an analysis of the duty-rostas on each ward for approximately one year prior to the commencement of observation was undertaken. The duty rostas were chosen as a source of data as they are working

documents, regularly consulted and altered according to last minute changes in the available staffing, and therefore more likely to reflect actual staffing levels than other sources of information.

The sisters on each of the wards were found to have kept sequential back copies of their duty rostas. Permission to photocopy these was sought and obtained from the sisters themselves and the senior nurse managers.

The period for analysis was primarily dictated by the fact that both the medical and gynaecology ward had only been in existence for about a year following the opening of the DGH. The number of weeks analysed on each ward's duty-rosta totalled 60 weeks for the gynaecology ward, 40 weeks for the medical ward and 52 weeks for the geriatric ward. The discrepancies in the periods covered reflects the fact that the gynaecology ward had all its duty-rostas going back to when the ward opened in the new hospital, however some of the earlier ones were missing from the medical ward. A straight year was taken for the geriatric ward as an arbitrary cut-off point.

AN ANALYSIS OF THE STAFFING STRUCTURE OBSERVED ON THE RESEARCH WARDS

This section presents an analysis of the staffing structures found on each of the three research wards. The data are presented in the form of tables and figures. Some of the data, e.g. that found in Figs 2, 3 and 4, resemble raw data.

This method of presentation is adopted because it provides the reader with a visual illustration of the patterns of staffing actually observed. It was felt that these data would have less impact if they were aggregated.

The Staffing Levels on the Medical Ward

A comparison of the official and actual staffing levels on day duty at the time of observation on the medical ward is given in Table Seven below in whole time equivalents (WTE's).

TABLE SEVEN
COMPARISON OF OFFICIAL AND IN-POST STAFFING LEVELS ON THE MEDICAL WARD

OFFICIAL	IN POST
1 WARD SISTER	1 WARD SISTER
4 STAFF NURSES	*3 STAFF NURSES
2.5 ENROLLED NURSES	3 ENROLLED NURSES.
8 LEARNERS	4 TO 7 LEARNERS
2.5 AUXILIARIES	3 PART TIME AUXILIARIES 1 32 hours per week 2 20 hours per week
TOTAL 18 WTE	TOTAL 14/16.3 WTE

*1 Staff Nurse left to do District Nurse training during the period of observation, reducing the number of staff nurses to three.

The Staffing Levels on the Gynaecology Ward

A comparison of the official and actual ward establishment on day duty at the time of observation is given below in Table Eight, in WTE's. The official establishment level was thought, by the nursing officer in charge of the unit, to be sufficient to cover annual leave, providing the learner nurse allocation was maintained.

The nursing management of the gynaecology ward was transferred from the Acute and Elderly Services to the Maternity Services three weeks after the new hospital was opened. This meant that agreed staffing levels for the ward rose from NR3 + 16% to NR3 + 22% + 6.5%. On acquiring the gynaecology ward the nursing managers of the Maternity Services reviewed the workload on the ward. The review consisted of a mini-survey of the number of patients on the ward, the number undergoing major surgery, and the number undergoing minor surgery over a three month period. As a result of this review, it was agreed that staffing levels should be increased to those given above. In order to do this money was transferred from the community midwifery services to the gynaecology services. This transfer was made possible by a surplus on the community midwifery budget created by difficulty in recruiting community midwives. This reinforces the distinction made above between the different sources for determining staffing levels. Clearly NR3 determined one "official" staffing level, agreed in principle by the managers, but they were only able to operationalise this level of staffing if sufficient money could be found in the budget to cover it. Moreover it was only implemented because of recruitment difficulties elsewhere in the District.

TABLE EIGHT
COMPARISON OF OFFICIAL AND IN-POST STAFFING LEVELS ON THE GYNAECOLOGY WARD

OFFICIAL	IN POST
1 WARD SISTER	1 WARD SISTER
3 STAFF NURSES	3 STAFF NURSES
3 ENROLLED NURSES	3 ENROLLED NURSES
1.66 AUXILIARIES	1.69 AUXILIARIES
6 LEARNERS	4 TO 7 LEARNERS
TOTAL 14.66 WTE	TOTAL 12.69/15.6 WTE

The Staffing Levels on the Geriatric Ward

A comparison of the official and actual staffing levels on day duty on the geriatric ward at the time of observation is given below in Table Nine, in WTE's.

According to the nursing officer in charge of the unit the hospital experiences difficulty in recruiting qualified staff and has never been able to compensate for the introduction of the 37½ hour week. This appears to be the case on this ward, where they have been unable to successfully recruit a second sister, despite the fact that money was available in the budget to fund this post. It is clear, therefore, that even if official staffing establishments can be determined and funded, local recruitment problems may be more important than official figures in determining the actual staff in post.

TABLE NINE
COMPARISON OF OFFICIAL AND IN-POST STAFFING LEVELS ON THE GERIATRIC WARD

OFFICIAL	IN POST
2.18 WARD SISTERS	$1 WARD SISTER
2.00 STAFF NURSES	*1.66 STAFF NURSES
4.00 ENROLLED NURSES	#3 ENROLLED NURSES
1.85 AUXILIARIES	2.37 AUXILIARIES
4/5 LEARNERS	1-4 LEARNERS
TOTAL 14.03/15.03 WTE	TOTAL 9.03/12.03 WTE

$ A second Ward Sister had been employed on the ward during the previous year she stayed for 10 weeks.

* 1 full-time staff nurse joined the ward during the period of observation. Bringing the total number of staff nurses on the ward to 1.66 WTE

1 Agency Enrolled nurse was working full-time on the ward and was included on the off-duty rosta. Bringing the total number of enrolled nurses on the ward 4 WTE.

Minimum Staffing Level Accepted On Each Ward

During the course of the observation another factor that emerged as affecting staffing levels on the ward was the use of bank and agency nurses. The data, given in figs 2, 3 and 4, provide an analysis of the use of agency and bank nurses observed on the gynaecology, geriatric, and medical wards respectively during the period of observation. They reflect the actual staffing levels found on each shift observed. Discussions with each of the sisters about staffing levels indicated that on each ward the duty-rosta was planned to provide a minimum acceptable number of staff for each early

KEY

* = Agency S/N on rosta
O/S = Off Sick
E = Early Shift
L = Late Shift

FIG. TWO

USE OF AGENCY AND BANK NURSES ON THE GYNAECOLOGY WARD

Shift	No. of Learners Allocated to Ward	Staff Establishment Including Learners	No. on Shift on Rosta	No. of Bank Nurses	No. of Agency Nurses	Total on Shift
E	7	15.39	6			6
L	7	15.39	4+1*			5
E	5	13.39	6			6
L	5	13.39	5			5
L	5	13.39	3+1*		1	5
E	5	13.39	4+1*		1	6
L	5	13.39	4+1*			5
E	5	13.39	5+1*		1	7
L	4	12.39	3+1*	1	1	6
E	4	12.39	4+1*	1		6
E	4	12.39	5 (2 O/S)		2	7
L	4	12.39	3	1	1	5
E	4	12.39	4+1*		1	6
E	5	13.39	4 (1 O/S)	1	2	7
L	5	13.39	2+1* (2 O/S)		1	4
L	5	13.39	3+1* (1 O/S)		1	5
E	5	13.39	6			6
E	5	13.39	5+1*		1	7
L	5	13.39	4	1		5
E	5	13.39	4+1* (1 O/S			5
L	5	13.39	5			5
E	5	13.39	6			6
L	5	13.39	4		1	5
E	5	13.39	6 (1 O/S)			6
L	5	13.39	3+1*		1	5
E	5	13.39	6			6
L	5	13.39	5			5
E	4	12.39	6 (1 O/S)			6
L	4	12.39	3 (Sr. at meeting)	1	2	6
E	4	12.39	6		1	7
L	4	12.39	3+1*	1		5
E	4	12.39	7			7

FIG. THREE

USE OF AGENCY AND BANK NURSES ON THE GERIATRIC WARD

Shift	No. of Learners Allocated to Ward	Staff Establishment Including Learners	No. on Shift on Rosta	No. of Bank Nurses	No. of Agency Nurses	Total on Shift
E	4	12.03	6			6
L	4	12.03	2	1		3
E	4	12.03	5			5
E	4	12.03	5			5
L	4	13.03	3			3
E	4	13.03	5			5
E	4	13.03	5			5
L	4	13.03	4			4
E	4	13.03	8			8
E	4	13.03	5			5
L	4	13.03	3			3
E	4	13.03	4+1 (borrowed from another ward)			5
E	4	13.03	4		1	5
L	1	10.03	3			3
E	1	10.03	4		1	5
E	1	10.03	4		1	5
E	1	10.03	3		2	5
L	1	10.03	3			3
E	1	10.03	3		2	5

FIG. FOUR

KEY
O/S = Off Sick

USE OF AGENCY AND BANK NURSES ON THE MEDICAL WARD

Shift	No. of Learners Allocated to Ward	Staff Establishment Including Learners	No. on Shift on Rosta	No. of Bank Nurses	No. of Agency Nurses	Total on Shift
L	4	13.13	2		2	4
L	4	13.13	4			4
E	4	13.13	5 (+ 1 nurse (from ITU)			6
L	4	13.13	3		2	5
L	6	15.13	6			6
E	6	15.13	6			6
L	6	15.13	5			5
L	5	14.13	5			5
E	5	14.13	6			6
L	5	14.13	4		1	5
E	5	14.13	5		1	6
L	5	14.13	4		1	5
E	5	14.13	5		1	6
L	5	14.13	4		1	5
L	5	14.13	4		1	5
E	5	14.13	4		2	6
L	5	14.13	3		2	5
L	7	16.13	4			4
E	7	16.13	5			5
E	7	16.13	5			5
E	7	16.13	5		2	7
L	7	16.13	4		1	5
E	7	16.13	5		1	6
L	7	16.13	3		2	5
E	7	16.13	5		1	6
L	7	16.13	5			5
L	7	16.13	6 (1 O/S)			5
E	7	16.13	7 (2 O/S)			5
L	7	16.13	7 (1 O/S)			6

and late shift on each of the three wards. Where shift numbers fell below this level on each ward, agency or bank nurses were employed to make the numbers up. This is confirmed in Figs 2, 3 and 4.

Fig. 2 demonstrates that on the gynaecology ward the sister planned the duty-rosta to provide a minimum of 6 nurses on an early shift and 5 on a late shift. She would accept 5 on an early shift and 4 on a late shift on a Saturday (the quietest day) provided 3 nurses were qualified on each shift.

Fig. 3 demonstrates that on the geriatric ward the sister planned the duty rosta to provide a minimum of 5 nurses on an early shift and 3 nurses on a late shift.

Fig. 4 demonstrates that on the medical ward the sister liked to have 7 nurses on an early shift and 5 on a late shift.

On each of the three wards where shift numbers fall below those given above, then, as Figs. 2, 3 and 4 demonstrate, agency or bank nurses are used to make the number working on the shift up to the level given above. Moreover, although it is clear that on a number of occasions agency and bank staff are used to compensate for sickness on the ward, by far the biggest use made of them was to supplement for an under-allocation of learners to each of the wards since the numbers used increased as the level of under-allocation went up. As can be seen from Figs 2, 3 and 4, for most of the

periods of observation the wards were under-allocated with learners. The observation took place over a six month period on all of the wards. The analysis of the duty-rostas given in Table Ten indicates the wards experience more under-allocation than over-allocation, suggesting, perhaps, that the learner nurse establishment for these wards needs to be adjusted, as clearly there were not enough learners available in the District to maintain this establishment.

The above analysis indicates that, on each of the research wards, the number of nurses per shift, rather than mix of staff or workload, is the critical factor determining utilisation of staff. It also indicates that greater importance is attached to the total number of nurses on duty irrespective of their grade or the degree of experience or skill they possessed. Therefore when planning duty-rostas all nurses, regardless of grade are treated as equal. This reinforces the suggestion, made in Chapter One, that the atheoretical perspective on nursing incorporated in traditional approaches to manpower planning derived from operational research, has simply reflected the current grade distinctions generated by traditional staffing establishments. The inability of this approach to differentiate between the demand for different grades of staff is therefore a product of the method used. The failure of nurse manpower research to provide any information on the demand for different grades of nursing staff has been the subject of Government criticism (National Audit Office 1985,

DHSS 1986). These findings, therefore, indicate the need to develop alternative approaches to nurse manpower, as suggested earlier.

The above analysis suggests that the number of nurses actually found on a shift is determined by the judgement of the sister as to what constitutes an adequate staffing level for that shift. A simple formula produced by the medical nursing officer was used to identify the total number of WTE staff required to meet this level of staffing on each of the three wards.

Meeting The Staffing Levels Desired By The Sister On The Medical Ward

On the medical ward the Nursing Officer aimed to provide 6 nurses (rather than the 7 required by the sister) on an early shift and 5 nurses on a late shift throughout the week. No account is taken of fluctuations in workload as no system existed to identify when fluctuations occur. In order to determine whether the establishment was sufficient to meet this level of staffing the Nursing Officer used the following formula.

Total WTE staff x total number of shifts worked by each WTE member of staff ÷ total number of shifts to be covered each week on day duty.

Applying this formula to the official Medical Ward staffing establishments gives 18 WTE multiplied by 5 (the number of shifts each WTE works a week) divided by 14 (the number of

day shifts to be covered each week).

$$18 \times 5 \div 14 = 6.5.$$

Therefore 18 wte staff provides an average of 6.5 nurses for each day shift [early and late shift]. Given a full staffing establishment there are enough nurses to provide the cover thought necessary by the Nursing Officer.

If the formula used by the medical Nursing Officer is applied to the maximum staffing establishment observed on the medical ward during the period of observation, the following result is obtained.

The maximum observed staffing establishment on this ward was 16.3 WTE.

$$16.3 \times 5 \div 14 = 5.8 \text{ WTE}$$

Therefore, during the period of observation, the maximum number of nurses available per shift was 5.8 WTE. This indicates that the under allocation of learners to this ward throughout this period meant that the level of cover, thought necessary on this ward by the Nursing Officer, could not be maintained. Instead, the ward was dependent on bank and agency staff to maintain staff cover.

Meeting The Staffing Levels Desired by the Sister On The Gynaecology Ward

The maximum observed staffing level on the the gynaecology ward was 15.69 WTE. If the formula developed by the medical nursing officer is applied to this figure it gives the following results.

$$15.69 \times 5 \div 14 = 5.6 \text{ WTE}$$

This indicates that 5.6 nurses are available per shift when the ward is one over its allocation of learners. This would appear to be only just enough to provide the ward with the 6 nurses on an early shift and 5 on a late shift thought necessary by the sister. If the official staffing establishment of 14.66 WTE staff is used in this formula the following result is obtained.

$$14.66 \times 5 \div 14 = 5.2 \text{ WTE}$$

This suggests that the official staffing establishment and most of the observed staffing establishment was insufficient to provide 6 nurses on an early shift and 5 on a late shift. Therefore this ward had to rely on agency and bank staff to compensate for any shortfall in the learner allocation and a funded staffing establishment that was insufficient to provide the minimum level of staffing planned by the sister. This level of staffing could only be obtained, without recourse to bank and agency staff, when there was an over allocation of learners to the ward.

Meeting The Staffing Levels Desired by the Sister On The Geriatric Ward

If the above formula is applied to the geriatric ward, the following results are obtained. The maximum official staffing establishment on the geriatric ward was 15.03 WTE staff (including maximum agreed allocation of 5 learners).

$$15.03 \times 5 \div 14 = 5.3 \text{ WTE}$$

The maximum observed staffing level was 14.03 WTE staff in post (including actual observed allocation of 5 learners).

$$14.03 \times 5 \div 14 = 5 \text{ WTE}$$

The minimum observed staffing level was 10.03 WTE (including actual observed allocation of 1 learner).

$$10.03 \times 5 \div 14 = 3.5 \text{ WTE}$$

These figures indicate that at both the funded (official) and maximum observed staffing levels there were sufficient nurses on the geriatric ward to provide the level of cover thought necessary by the sister. However, at the minimum observed staffing level, created by an under allocation of learners, there were insufficient nurses working on the ward to maintain the level of cover thought necessary by the sister, and again the ward had to resort to the use of bank and agency staff to maintain staffing levels.

The Effect Of Learners On Ward Staffing Levels

The above analysis, taken from the staffing patterns actually recorded during the course of observation on the three wards, indicates that number of nurses per shift is the critical factor in planning duty rostas. The application of the formula used by the Medical Nursing Officer to each of the three wards' official and observed staffing levels indicates that on both the medical and geriatric ward the planned level of cover could be achieved providing the learner nurse allocation was maintained at the agreed level, on the gynaecology ward it had to be maintained at slightly above the agreed level. Any under allocation of learners would be compensated by the use of bank and agency staff.

Table Ten is an analysis of the learner nurse allocation patterns identified from the duty rostas for each ward for the respective periods of time given above. It demonstrates substantial fluctuations in the allocation of learners to each of the three wards over the period of analysis. It indicates that for 47% of the time period on the gynaecology ward, 65% of the time period on the medical

TABLE TEN
FLUCTUATIONS IN THE ALLOCATION OF LEARNER NURSES TO EACH WARD FOR THE YEAR PRIOR TO THE RESEARCH

	NUMBER OF WEEKS		
	SURGICAL	MEDICAL	GERIATRIC
1 under agreed level	11	12	10
2 under agreed level	14	3	8
3 under agreed level	3	7	2
4 under agreed level	-	3	-
5 under agreed level	-	1	-
1 over agreed level	4	5	6
2 over agreed level	8	1	3
3 over agreed level	4	2	-
4 over agreed level	1	2	-
5 over agreed level	2	-	-
Total No.Weeks.	60	40	52
Agreed level allocated	13(22%)	4(10%)	23(46%)
Total No.Weeks under agreed level	28(47%)	26(65%)	20(38%)
Total No.Weeks over agreed level	19(31%)	10(25%)	9(17%)

ward, and 38% of the time period on the geriatric ward, there was an under allocation of learners, and the ward was dependent on bank or agency nurses to provide the desired level of cover. For management reasons these nurses worked only one or two shifts at a time, thus adding to an already unstable staffing situation. This situation is discussed further in the section on bank and agencies nurses given below.

The Effect Of Learners On The Stability Of Ward Staffing

Table Eleven gives the average length of stay for learners on each ward derived from the analysis of the duty-rosta. It also attempts to depict the level of turnover experienced by each ward over the period analysed, caused directly by the

TABLE ELEVEN
STAFF TURNOVER CREATED BY THE SECONDMENT OF LEARNER NURSES TO STAFF THE RESEARCH WARDS

WARD	GYNAECOLOGY	MEDICAL	GERIATRIC
No.Weeks. analysed	60	40	52
No.Learners allocated	35	29	44
Average length of stay	8.8wks.	8.5wks.	5wks.
Minimum length of stay	2wks.	2wks.	4wks.
Maximum length of stay	23wks.	14wks.	6wks.
No. of wks staff changed	42	31	46
No.Wks. same staff as previous week.	18wks	9wks.	8wks.

throughput of learners. It highlights the extremely fluid staffing situation experienced on all 3 wards. Both the medical and gynaecology ward had an average length of stay of about 8 weeks. To accommodate this, they were allocated a new learner on average once every two weeks. The geriatric ward had a length of stay of approximately 5 weeks and averaged a new learner nearly every week. There was no pattern to these changes. A ward could go from a period of over allocation one week to a period of under allocation the next. As learners form such a large proportion of the staffing establishment, this creates a very unstable staffing situation.

The Use of Agency and Bank Nurses

As was demonstrated above, agency and bank staff are used on all three wards primarily to make up for a shortfall in the learner nurse allocation. Only on the geriatric ward was an agency nurse employed full-time to make up for a shortfall in the number of permanent staff.

Table Twelve gives the number of bank and agency nurses, observed by the researcher, employed on each ward for a temporary period of one or two shifts. It does not include agency nurses employed for longer periods of time on the duty rosta. Therefore the agency enrolled nurse on the geriatric ward is not included, and neither is an agency staff nurse, employed full time on the gynaecology ward to compensate for a long period of time when there was a known shortfall in learners.

TABLE TWELVE
SHIFTS OBSERVED EMPLOYING BANK AND AGENCY STAFF

	NO. SHIFTS OBSERVED	AGENCY	BANK	TOTAL
GYNAE.	32	18	7	25
GERIATRIC	20	7	1	8
MEDICAL	32	21	0	21
TOTAL	84	46	8	54

Table Twelve shows that on over half the shifts observed agency or bank nurses were used on a temporary basis of one or two consecutive days to compensate for a shortfall in learner nurses. It has already been shown that learners accounted for between a third and a half of the staffing establishment necessary to staff the wards to the level considered acceptable by the sisters. Table Ten indicates that for over a third to half the time the wards were under the agreed learner nurse establishment level, and therefore dependent on agency and bank staff. This suggests that the use of learners to staff hospitals creates an extremely unstable staffing situation at ward level which gives rise to additional costs for the Health Service in the form of agency and bank nurse salaries.

Table Twelve indicates only minimal use of bank nurses on all three wards compared to agency nurses. The only ward that used bank nurses with any degree of consistency was the

gynaecology ward. This reflects a differing management policy towards the use of bank nurses by the Maternity care group managers, compared with the managers of the Acute and Elderly care group.

The Nursing Officer for the medical ward did not use bank nurses because they could only be booked at short notice on the Monday morning for that week. Often he found they were not available, and he had to book agency nurses at very short notice. The reason given for this short booking period was that bank nurses were unwilling to commit themselves for more than a week at a time. Agency nurses on the other hand, could be booked up to four weeks in advance.

However, despite the fact that agency nurses could be booked well in advance to compensate for a known shortfall in the allocation of learners, they were only booked for one or two days at a time. This reflected prevailing management policy within the Acute and Elderly care group. In this care group Nursing Officers who wanted to book agency nurses for more than three days at a time had to request permission from the Assistant Director of Nursing Services (ADNS) for this care group. This was to enable the Director of Nursing Services for this care group to identify persistent vacancies in nursing personnel. The Nursing Officer was unwilling to keep obtaining permission from the ADNS, particularly when he was booking agency nurses to compensate for a reduced allocation of learners.

In the Maternity care group the above policy did not apply. Agency nurses were booked directly by the ward sister for any length of time she thought necessary. The manager of the Maternity services had also developed an informal arrangement with the manager of the bank nurses. Under this arrangement the Sister was able to contact the bank nurses personally, book them for a mutually agreed period of time, and inform the bank nurse manager of the nurses she had booked and when. This arrangement enabled the sister to develop a small group of bank nurses whom she booked regularly. As indicated in Appendix M, Table D, there were in fact three bank nurses that were regularly employed on this ward. Moreover, because the bank nurses worked consistently within the same care group, often on the same ward, they were prepared to commit themselves for much longer periods of time. They were frequently entered on the duty rosta for up to four weeks in advance. They were also prepared to come in at very short notice, the same afternoon on one occasion, if needed under exceptional circumstances.

Manpower Planning In The Context Of Learner Nurse Allocation Patterns

The above analysis raises a number of issues in relation to traditional approaches to nurse manpower planning. Firstly, it suggests that wards with a full complement of nurses according to "official" staffing formulas could be short staffed if under allocated with learners. This will lead to a demand for bank and agency staff, that may not be

predicted in management budgeting.

Secondly, it is interesting to note, that using the official definition of staffing establishments for each ward, the only ward that was permanently understaffed for qualified nurses was the geriatric ward. Moreover, for most of the period of observation, it was also under-allocated with learners. Given this situation, one would expect to see more agency and bank nurses used on this ward than on the other two wards. However, as Table Twelve indicates, this was not the case. In fact, far fewer agency and bank staff were used on this ward than on the other two wards. This suggests that the staffing levels thought acceptable by the sisters on each ward are derived, not from the official formulas which measure demand, but from historically established patterns of staffing on the ward. These established patterns are derived from the local availability of staff. If a ward is understaffed for a long period of time (using the official figures) it will adjust its workload to accommodate this situation. This will then become the norm used by the sister to determine her actual staffing needs. She will only consider the ward understaffed when levels fall below the established pattern.

This finding has implications for nurse manpower planning, Firstly, it confirms the suggestion made in Chapter One, that changes in the number of learners recruited, possibly in response to projected demands for qualified staff calculated using "official" demand formulas, will affect the

local demand for staff at ward level. This arises from the fact that changes in the throughput of learners affects the total number of nurses available to work a given shift. An under-allocation in learners to a clinical area will result in an increased demand for bank and agency staff, while an increase over a prolonged period of time could affect the subsequent demand for staff in that unit.

Secondly, changes in the training programme, such as those proposed in Project 2000 (UKCC 1986), could have parallel repercussions. Supply formulas currently being developed to assist managers to calculate replacement levels following the introduction of Project 2000, operate at national (UKCC 1987), or Regional levels (Department of Health 1989). They are, therefore global models which assume a relatively even distribution of learners to clinical area, across the District. In this District this was clearly not the case. Wards which traditionally received a large number of learners are likely to demand more staff replacement than wards which have suffered from chronic low levels of staffing. This suggests that, in planning replacement, it is necessary to calculate the modal allocation of learners to a ward under the traditional training scheme, and subtract from this any allocation to the ward planned from the 20% contribution made in the final year. This will indicate the demand that the sister will make through bank and agency services for learner nurse replacement following the implementation of Project 2000. A model based on these

principles has been developed by Newcastle Health Authority (Quinn et.al. 1989).

THE EFFECTS OF LEARNERS ON CONTINUITY OF CARE

The above analysis highlights the transient nature of ward staffing created by dependence on a learner nurse workforce. If we return to the original funded staffing establishment, we find that learners make up 44% of the medical ward staffing establishment, 31% of the geriatric ward staffing establishment, and 40% of the gynaecology ward staffing establishment. This, coupled with the dependence on agency and bank staff created by an under-allocation of learners, suggests that, on being allocated to a ward, the learner does not enter a stable work environment where they can be incorporated in an established team. Instead, it is the pattern of learner nurse allocation to the ward that determines the staffing structure found on nurse training wards. This has clear implications for the introduction of systems of patient allocation. As discussed in Chapter One, the allocation of unqualified staff including learners, to patients, has never been adequately resolved.

This problem is discussed by Marram, Schlegel and Bevis (1974) and by Hegyvary (1982) both of whom highlight the difficulties experienced by team leaders in the USA, in organising the allocation of work to nurses with varying degrees of experience, some of whom were aides. They point

out that dependence on the wide skill range found in nursing meant that inevitably task allocation persisted within team nursing. This led them to recommend the introduction of primary nursing.

Primary nursing is distinguished by the fact that a single senior nurse is given 24 hour accountability for the care given to patients. This system is described by McFarlane and Castledine (1982), who suggest that a primary nurse should be a registered nurse allocated to the patient and responsible for planning all the patient's care needs for the duration of the patient's stay. A second nurse, usually a learner or auxiliary, should also be allocated to the patient. This nurse works with the primary nurse and cares for the patient when the primary nurse is off-duty. However, they recognise that the constraints of the off-duty do not permit primary and second nurses always to work opposite each other, therefore all nurses on the ward serve as associate nurses, who may be asked to implement the planned care in the absence of the primary or second nurse.

Similarly, Hegyvary (1982) and Marram, Schlegel and Bevis (1974) both recognise that primary nursing is distinguished by 24 hour accountability for patient care as described by McFarlane and Castledine (1982) above. Moreover, they emphasise that in primary nursing both delegation and accountability proceed directly through the primary nurse, and not through a supervisorial third person ie., the qualified nurse on duty with the second or associate nurse.

In the description given by McFarlane and Castledine (1982) it is clear that both learners and auxiliaries act as second or associate nurses in the absence of the primary nurse. However, it is not clear who is responsible for supervising the care given by learners and auxiliaries when the primary nurse is off-duty.

The literature on primary nursing appears therefore to contain two assumptions:-

1.That a distinction exists between planning care which is seen as the province of the qualified nurse, and implementing care, which can be allocated to unqualified learner and auxiliary nurses. This assumes that the learner or auxiliary possesses all the skills necessary to implement every aspect of planned care.

2.That it will not be necessary to change the care plan in the absence of the primary nurse. If it is necessary, it is not clear from the literature who has the authority to authorise the changes, the learner or auxiliary acting as second nurse in the absence of the primary nurse, or a qualified nurse acting as primary nurse to another group of patients, and therefore unfamiliar with the care needs of the patient in question.

As discussed above, each of the wards had implemented a system of patient allocation, however, as the following description indicates, the need to supervise learners and

other transient staff prevented nurses from being permanently allocated to a group of patients. Instead, very little continuity in care was found, despite attempts on each of the wards to promote this.

Patient Allocation on the Geriatric Ward

If we take the first assumption, this can be examined by an analysis of the organisation of care on the geriatric ward. This ward consisted of 36 beds. For the purposes of patient allocation the patients were divided into four groups consisting of nine patients each (see Appendix F). Patient allocation occurred only on early shifts, as this was the only time there was sufficient nurses on duty to allocate one nurse to each group of patients. On this ward patient allocation was seen as a learning exercise. Table Eleven indicates that the average length of allocation for a learner was five weeks. The official learner allocation was 4/5 learners. Therefore the sister had devised a system whereby each learner was allocated to a group of patients for a week. At the end of the week the learners rotated.

This system enabled each learner to nurse all the patients on the ward for one week during their placement. On all early shifts the learner nurse worked with her allocated group of patients. On a late shift she joined the other two nurses and worked with all the patients as part of a team. As each learner only works an average of three early shifts a week there are four mornings when they are unavailable to

nurse their group. To overcome this problem, the qualified staff compiled a weekly patient allocation list. This allocated the permanent staff on duty each morning to the groups of patients not covered by learners who were off-duty. The need to promote continuity of care was recognised, and as far as possible the permanent staff were allocated to the same group for each early shift they worked that week.

As there was rarely more than five nurses on duty on an early shift, given four groups of patients, one nurse was assigned to each group and the fifth (usually the auxiliary) floated. Patient allocation therefore involved delegating the total care of a group of patients to a learner nurse. This implies that either this nurse must possess all the skills necessary to provide unsupervised total patient care for all the patients in the group to which she has been allocated, or some of the care must be given by a qualified nurse caring for another group of patients. This is particularly true when it is the auxiliary that is floating. If there is insufficient work contained in one group to occupy a nurse for the entire duration of the shift, then some time will be available to the qualified nurse to both supervise learners caring for other groups of patients, and attend to the needs of patients in the other groups that cannot be met by the unqualified staff allocated to them. If this is the case, then the use of unqualified staff must lead to overstaffing as clearly unqualified nurses will not be fully occupied caring for their group of patients for the

entire shift.

Alternatively, if there is enough work in each group to fully occupy a nurse for the duration of the shift but not all of this work can be done unsupervised by an unqualified nurse, then if the qualified nurse is to do some of the work required by patients allocated to a learner nurse, the unqualified nurse must relieve the qualified nurse of some of her work for her group. It would appear we are back into task allocation and that it is the use of unqualified staff rather than method of work organisation that creates fragmentation.

Continuity of Care on the Geriatric Ward

Despite attempts on this ward to achieve continuity in the care given to patients, Appendix K indicates that very little was actually achieved. It could be argued that greater continuity could have been developed if learners and qualified staff were allocated permanently to one group of patients. However, as the above discussion indicates, qualified staff need to be aware of the needs of all the patients on the ward, in order to supervise care given by bank, agency, auxiliary and learner nurses. If they were allocated permanently to one group, they may become out of touch with the care needs of patients in the other three groups, and therefore might be less able to supervise learners in their care of these patients.

The introduction of primary nursing is likely to complicate

still further this situation, as it is not at all clear from the literature, who is responsible for taking decisions about care in the absence of the primary nurse; the unqualified second or associate nurse, or the qualified nurse who is acting as primary nurse to another group of patients, and who therefore has very little knowledge about the care needs of this patient. It would appear that while wards are primarily dependent on unqualified staff to implement much of the care given to patients, then the qualified staff will need to nurse all the patients on the ward in order to be familiar with their care needs and therefore able to take decisions about that care and supervise learners in the absence of the primary nurse. This is supported by Pearson (1988) who points out that the successful introduction of primary nursing requires a fully qualified workforce

Patient Allocation on the Medical Ward

The system of patient allocation introduced by the sister on this ward divided the patients into two groups, A and B, and allocated the nurses on duty each day to one of the two groups. The decision to divide the ward into two groups reflected the importance attached by the sister to the allocation of a qualified nurse to each group every shift.

Table Thirteen indicates that of the 64 group allocations observed on this ward there were only 2 occasions when the most senior nurse allocated to a group of patients was an unqualified nurse, and 4 occasions when it was an agency

nurse. However, of the remaining 58 group allocations observed, there were 25 occasions when the qualified nurse in charge of a group was also running the ward. Despite this, the sister felt that this was the only means by which

TABLE THIRTEEN
ALLOCATION OF QUALIFIED STAFF TO PATIENT GROUPS ON THE 32 SHIFTS OBSERVED ON THE MEDICAL WARD

SHIFTS OBSERVED 32 GROUP ALLOCATIONS OBSERVED 64

NUMBER OF GROUPS SUPERVISED BY:-	
STAFF NURSE (exclusively)	8
STAFF NURSE P/T late shift 4pm-9pm	5
ENROLLED NURSE (exclusively)	20
SISTER (+ running the ward)	7
STAFF NURSE (+ running the ward)	18
AGENCY STAFF NURSE	1
AGENCY ENROLLED NURSE	3
UNQUALIFIED NURSE	2
TOTAL	64 GROUPS

Number of shifts the sister floats = 5.

Number of shifts a staff nurse floats = 2.

Number of groups with more than one permanent qualified nurse allocated to it for the duration of the shift = 3.

accountability for care provision could be maintained on the ward, as she found it difficult to identify patients whose total care could be allocated to an unqualified nurse, even if that care was planned. However, it created two large groups of patients which were still dependent on learners and auxiliaries to give much of the care. Because of the difficulties of allocating unqualified nurses to patients, it was accepted that within teams work was assigned using task allocation.

Continuity of Care on the Medical Ward

Again, continuity of care was considered important on this ward. Attempts were made to promote this by, where possible, allocating nurses to the same group of patients they were assigned to the previous day. Appendix K indicates however, that again very little actual continuity was achieved. This is particularly true if we look at the mix of staff allocated to a group. Appendix K is broken down so that the allocation of individual nurses, rather than just their grades, is indicated. It suggests that in 2 months of observation the same individual mix of nurses was allocated to group A on two occasions and group B on five occasions.

However, continuity of allocation to a geographically defined group of patients on this ward did not necessarily give rise to continuity in patient care, as patients were frequently moved around the ward. The sister recognised this, but felt that allocating nurses to individual patients would create greater confusion, as the patients would be distributed across the ward, instead of grouped together.

Patient Allocation on the Gynaecology Ward

The sister on the gynaecology ward had introduced a system of team nursing. Here there were three teams of nurses, made up of a staff nurse and an enrolled nurse; learners and auxiliaries were attached to each team. The patients were divided into three groups and stayed under the care of the team for the duration of their stay. However, again this ward experienced difficulty in maintaining qualified cover

on all three teams.

Table Fourteen is an analysis of the most senior nurse attached to each group of patients for each of the 32 shifts observed. A total of 96 group allocations were observed (32 shifts x 3 groups of patients). On 53 of the 96 group allocations the most senior nurse allocated to that group for that shift was a member of the team of nurses attached to the group. Of these 53 occasions, on 11 occasions the senior nurse was a third year student nurse and on one occasion a second year pupil nurse; the remaining 41 occasions were covered by the staff nurse or enrolled nurse attached to the group.

For the other 43 group allocations observed, a variety of arrangements were used by the nurses to cover the group of patients. The need for these arrangements arose because the nurses on duty for the team were either learners or auxiliaries who could not be left in charge of a group of patients unsupported, or there were no nurses from that team on duty.

In either situation bank or agency staff on duty were allocated to cover that team. If they were not available the group of patients were divided between the other 2 teams. Occasionally a qualified nurse would supervise 2 teams, or an enrolled nurse would swap to cover another team.

The arrangement most commonly used when there was inadequate

TABLE FOURTEEN
THE MOST SENIOR NURSE OBSERVED TO BE ALLOCATED TO THREE GROUPS OF PATIENTS ON THE GYNAECOLOGY WARD

SHIFTS OBSERVED 32 GROUP ALLOCATIONS OBSERVED 96

NUMBER OF GROUPS SUPERVISED BY:-	Team A	Team B	Team C	Total
S/N of team (exclusively)	2	5	5	12
S/N of team (+RW)	1	4	6	11
E/N of team (exclusively)	8	3	6	14
E/N of team (+RW)			4	4
3rd year ST/N of team	8	3	0	11
2nd year P/N of team	0	0	1	1
SUBTOTAL				53
*Agency S/N	1	2	6	9
*Agency S/N +split group	0	0	1	1
*Agency S/N +RW	0	0	1	1
Bank S/N A.	4	2	1	7
Bank S/N B.	0	6	1	7
Bank S/N C.	0	1	0	1
S/N from another team + RW	0	1	0	1
S/N from another team + OG+RW	0	0	1	1
E/N from another team	2	0	0	2
3rd year ST/N from another team.	1	0	0	1
Agency S/N A.	0	1	0	1
Agency S/N B.	1	0	0	1
Agency S/N C.	2	1	1	4
Agency E/N A.	1	0	0	1
Agency E/N B.	0	2	0	2
Agency E/N C.	0	1	0	1
Split Group	1	0	1	2
SUBTOTAL				43
TOTAL				96

KEY:- RW = Plus Running the Ward
OG = Own Group
* = Agency Staff Nurse working full time on the ward for a temporary period of time.
S/N = Staff nurse
E/N = Enrolled nurse
ST/N = Student nurse
P/N = Pupil nurse

cover for one group of patients was to allocate bank or agency staff to cover that group for the duration of the shift. On 25 of the 32 shifts observed, bank or agency nurses were employed. As these only consisted of qualified staff (RGN or EN), they were available to cover those groups not covered at all or only covered by unqualified staff. As Table Eight demonstrates, this occurred on 37 occasions.

Continuity of Care on the Gynaecology Ward

The introduction of team nursing does not, therefore, appear to overcome the problems of continuity described on the other two wards. As Appendix K demonstrates, out of a total of 32 shift allocations observed for each of the three teams, 22 different mixes of staff were identified for Team A, 23 different mixes of staff were allocated to Team B, and 24 different mixes of staff were allocated to Team C. Again, this can be traced to the high turnover in staff created by an under-allocation of learners, and the need to provide adequate supervision of unqualified nurses.

CONCLUSION

This chapter has demonstrated that dependence on a learner nurse workforce can give rise to a highly volatile staffing structure which is exacerbated by the use of agency and bank nurses to compensate for an under-allocation of learners. It has also indicated the link between the modal allocation of learners, and demand for qualified staff in the form of bank and agency nurses. These findings appear to be crucial to

any accurate calculations of the replacement of learners following the implementation of Project 2000 (UKCC 1986).

The above analysis also demonstrates that wards can be under-allocated with learners for considerable periods of time (on these wards under-allocation occurred for approximately six months out of each year). This suggests that when changes in the recruitment of learners occurs there is a need to identify the effects on the allocation of learners to wards, so that managers can plan more permanent replacement strategies. However, the under-allocation, though totalling approximately six months, is sporadic, which makes permanent replacement difficult to maintain.

Finally, the above discussion indicates that on each ward the introduction of patient allocation was constrained by the need to provide adequate supervision of unqualified nurses. As a result the medical ward contained only two teams of nurses. The surgical ward introduced three teams, which were however, subject to a variety of leadership arrangements in order to ensure qualified cover. On the geriatric ward the low level of staffing meant that patient allocation was only feasible on early shifts, and again continuity was undermined by the need to supervise unqualified staff. Moreover, as the above analysis suggests, within the teams work was frequently allocated using task allocation. The difficulty, experienced on both the medical and surgical ward, of identifying patients whose needs could be fully met by unqualified staff, indicates that the

fragmentation of nursing work associated with task allocation is, in fact, a product of dependence on an unqualified workforce. It is therefore likely to persist despite the introduction of systems of patient allocation, while wards are dependent on unqualified nurses.

The instability in the staffing structure found on each ward also created problems for the collection of the observation data. The original plan for this stage of the research is given in Chapter Two. This assumed that it would be possible to ask the nurses, in advance of care giving, to undertake an assessment of the patient, and to identify the aims of care that they felt were pertinent to the specific needs of this patient. This was an important aspect of the collection of observation data as it identified the appropriate observation schedules, which highlighted the categories of care to be used to observe each patient. However, given the unstable staffing structures found on each of the wards, this method had to be revised. The next chapter describes the revisions made to the methodology in the light of the unstable staffing structures described above.

Chapter Five

The Revised Methodology

Reference to Chapter Two indicates that the intention was to collect the observational data using the schedules developed from the modified Delphi survey. As discussed in Chapter Two it was assumed that the nurses would be able to complete the observation schedules prior to the collection of the observation data. In practice, however, a number of difficulties were encountered with this proposal. This chapter describes these difficulties and how they were overcome. Firstly, the use of three levels of dependency in the Delphi survey was found to be an inadequate basis for capturing data on the wards. Secondly, it was found that the collection of the observation data had to be modified in the light of the transient, adhoc staffing structures described in the previous chapter.

It was not possible to pilot this aspect of the research as the observation schedules were not available until the Delphi survey had been completed. The open-ended nature of the survey meant that the results could not be predicted in advance.

THE DEVELOPMENT AND MODIFICATION OF THE OBSERVATION SCHEDULES

The first ward on which data were collected was the long-stay geriatric ward. The first few weeks on this ward were spent developing the observation schedules from the survey

data. During this process it became clear that some adaptations would have to be made to these data if they were to be used to structure the observation.

In order to match the patients observed to the survey data, each patient's dependency level was identified using the nursing assessment (Appendix G) and scoring system described in Chapter Three. Some patients were, however, found not to fit neatly into the dependency profiles developed for the survey. For instance, on the geriatric ward some of the patients who were confused or disorientated were still physically mobile and potentially independent of nursing staff. These patients were classified as medium dependency patients by the assessment, but contrary to the medium dependency profile, they were unable to identify their own physical needs, neither were they necessarily dependent on nursing staff to maintain these needs. Instead they were sometimes able to attend to their own care needs once these needs were identified by the nursing staff. Under these circumstances, a patient might be incontinent because they could not find the toilet, not because they lacked physical control. Similarly, they might be quite capable of dressing or feeding themselves once they had located their clothes or food.

This highlighted the need to develop a more flexible approach to matching the assessed needs of patients with the aims of care incorporated in the observation schedules. If

we return to the assessment given in Appendix G, it is clear that for each activity of living included, the patient is given a score of 0, 1, 2, or 3. Zero indicates total independence for that activity of living, and therefore largely reflects the low dependency category. Three indicates total dependence on nursing staff for that activity of living, and therefore largely reflects the high dependency category. Scores 1 and 2 predominately reflect the needs of medium dependency patients. The assessment, therefore, provided an overall classification of each patient's dependency level, which also identified the activities of living in which they deviated from this level of dependency. For instance, a low dependency patient may be fully independent on the ward, but have difficulty managing stairs, or preparing food. Conversely, a medium dependency patient may become a low dependency patient once appropriate bath, toilet, dressing, and/or feeding aids had been provided.

This suggested the need to match the observation schedules to both the patient's score for each activity of living, and to their overall dependency classification. As a result, observation schedules were developed which reflected the aims of care for each level of scoring (0, 1, 2, or 3), for those activities of living which were covered by the assessment and by the survey. Using this method, separate observation schedules were derived for the activities of living given in Fig 5 for each of the scores specified. The

FIG. FIVE

SCHEDULES DEVELOPED USING CATEGORIES OF CARE FOUND IN THE NURSING ASSESSMENT AND THE DELPHI SURVEY.

Communication	SCORE	0 1 2 3	Feeding	SCORE	0 1 2 3
Bathing	SCORE	0 1 2 3 (low and medium dependency patients only) 3 (high dependency patients only)	Sociability	SCORE	0 1 2 3
Continence (urine)	SCORE	0 1 2 3	Continence (faeces)	SCORE	0 1 2
Mobility	SCORE	0 1 2 3	Dressing	SCORE	0 1 2 3

actual observation schedules from which Fig 5 is taken are given in full in Appendix E.

In developing the schedules to reflect the four levels of scoring, rather than the three levels of dependency, some adjustments had to be made. These were made during the first few weeks of observation by the researcher as a result of

preliminary data collection and analysis. As can be seen from Fig 5 and Appendix E, certain scores for some of the activities of living are found in more than one schedule. This is because the aims of care for that activity of living depended on the patient's overall dependency profile. For instance, the aims of care for blanket bathing were given for the high dependency patient only, however, a number of medium dependency patients were found to require a full blanket bath i.e. following surgery, or following a myocardial infarction. As these patients were not confused, and were able to indicate their own needs, they conformed more to the medium dependency profile. Aims of care for medium dependency patients who required a blanket bath were abstracted, therefore, from the survey data; they incorporated some of the aims for high dependency patients, but reflected the medium dependency profile.

A similar situation was also found for feeding. Patients who scored three for this activity of living i.e. had to be fully fed, could in fact, conform to either a medium or high dependency profile. Different aims, which reflected the characteristics of the different profiles, were therefore abstracted for these patients. No schedule was developed for score 3 for faecal elimination as this applied only to patients with a colostomy, this was not covered in the survey, therefore aims of care were not available. Finally, the schedules for mobility for patients who scored 1, 2 or 3, i.e. who were immobile, contained a separate section for

continent patients on how they acquired access to the toilet. As the analysis of care given in Chapters Six and Seven suggests, this was an important aspect of care for which aims were available. For convenience these were incorporated in the schedule on mobility.

ASSESSING THE PATIENT'S LEVEL OF DEPENDENCY

The nursing assessment developed by Hunt (1982) which is given in Appendix G, was used throughout the observation stage of the research to match patients' needs to the aims of care identified in the observation schedules. As a result of the above analysis, it was used to select the observation schedules which reflected both the patients individual score for each activity of living, and their overall dependency level. The development of four levels of schedules, instead of three, produced considerable overlap between the schedules. This did not, however, affect the data collection, because each patient only had one schedule for each activity of living.

Inter-rater Reliability and the Nursing Assessment

It was recognised that asking the nurses to complete the assessment on the patients gave rise to the problem of inter-rater reliability. One method of overcoming this problem would have been for the researcher to complete the assessment on all the patients. However, the early field work suggested that to do so it was necessary to participate in the care of the patient, otherwise it was difficult to

know how much help a patient required with each activity of living without asking the nurses. Early pilot work also indicated that participating in the care given to patients undermined observation of the normal course of events. It also made it difficult to accurately record what actually did happen. Consequently, the nurses were asked to complete the assessment. In doing this, it was recognised that no inter-rater reliability checks had been undertaken on the assessment, and therefore nurses might give different classifications for the same patient.

The concept of inter-rater reliability implies that an objective measurement of the patients dependency level is required. This is necessary when standardisation is required for the purpose of comparison or correlation analysis. As there was no intention in this research to carry out either of these two procedures, it seemed in keeping with the qualitative perspective adopted to accept the interpretation given to the assessment by the nurse. To do otherwise assumes a correct/incorrect response. No such judgements were being made. Instead, once the scores were specified by the nurse the aims of care for that patient could be identified. The use of the nurse's judgement appears to support the professional definition of nursing adopted by this research, and to recognise the element of uncertainty which characterises such work. Consequently, it is possible to argue that varying assessments of the same patient are not a consequence of an unreliable assessment but simply an

expression of differing professional judgements. To attempt objectivity is to judge one assessment right and the other wrong. This presupposes criteria are available to do this. In this research, this was not the case.

THE SELECTION OF PATIENTS FOR OBSERVATION

A total of 66 days were observed by the researcher over all three wards.

21 days were observed on the geriatric ward.
23 days were observed on the medical ward.
22 days were observed on the surgical ward.

Observation took place over a two to three month period on each ward. Early and late shifts were observed on all three wards. Every day of the week including the weekends were covered in the observation on each ward. Night duty was excluded, primarily because no learners were working night shifts on any of the three wards at the time the research was undertaken.

The first week on each ward was spent familiarising myself with the organisation of care on the ward, and getting to know the nurses. A general explanation reflecting the aims of the research was given to each nurse. They were told that I was interested in how the care given to patients was affected by dependence on learner nurses. The possibility of making learners supernumerary to service requirements was discussed, and it was suggested that we needed to know what learners did now, if we were going to assess the effects of

this on the provision of patient care in the future. Some reservations about being observed were expressed by some of the nurses, but these were remarkably few. Most of the nurses appeared very keen to discuss what they did and why they did it.

As can be seen, although 66 days were spent observing care, only 42 patients were observed, as some of the days were used for general observation. On days used for general observation, the nurses on duty would be asked to use the nursing assessment to assess each of the patients in the group to which they were allocated. This gave a composite picture of the range of dependency levels on the ward, and brief information about each patient. This information was used to select one or two patients for observation over the next two or three days. Therefore, a rotating sequence of observation was set up, with general days being followed by days observing the care given to one or two patients. General days were spent with the nurses, observing the management of the ward and discussing the research. The aims of care included in the observation schedules were frequently discussed, and, where possible the observation schedules for patients to be observed, as well as the assessments, were completed by the nurses.

Days spent collecting data on specific patients could be spent in quite peripheral areas of the ward where sometimes nothing happened for literally hours. In an attempt to reduce the amount of data that could be lost by care being

given when the researcher took breaks; tea, coffee and lunch breaks were taken with the nurses giving care to the patient being observed. I very quickly became familiar with the organisation of care on the ward, and able to judge when it was appropriate to take a break.

Table Fifteen gives the number of assessments completed on each of the three wards. More than one assessment could be undertaken on an individual patient. It indicates that most of the patients on all three research wards fell into the medium and low dependency category. Therefore, most of the

TABLE FIFTEEN
ASSESSMENTS COMPLETED BY WARD AND DEPENDENCY

	Patient Dependency			
Ward	High	Medium	Low	Total
Geriatric	5	28	4	37
Medical	5	36	55	96
Surgical	1	52	54	107
Total	11	116	113	240

patients observed were derived from these two categories. A higher number of medium dependency patients were observed than low dependency patients, as low dependency patients were found to receive only a small amount of care from learners, and therefore the contribution of learners to patient care was difficult to assess from an analysis of the care given to these patients.

The individual care given to a total of 42 different patients on all three wards was observed as illustrated in Table Sixteen. The relatively low number of patients observed on the geriatric ward reflects the fact that this was the first ward on which observation was undertaken, and a lot of time was spent on this ward developing the observation schedules.

TABLE SIXTEEN
PATIENTS OBSERVED BY WARD AND DEPENDENCY

	Patient Dependency			
Ward	High	Medium	Low	Total
Geriatric	1	6	2	9
Medical	3	8	5	16
Surgical	1	12	4	17
Total	5	26	11	42

SYSTEMS OF PATIENT ALLOCATION AND NURSE PARTICIPATION IN THE RESEARCH

In order to discuss the care needs of the patients with the nurses giving care, it was necessary to identify in advance the nurses that were allocated to give care to the patient under observation. As the last chapter illustrates, in practice this was actually quite difficult to do, as there was very little continuity in the allocation of nurses to patients from one day to the next.

Data Collection on the Geriatric Ward

The first ward on which observation was carried out was the

long-stay geriatric ward. The system of patient allocation used on this ward is described in Chapter Four. It indicates that on this ward patient allocation was planned on a weekly basis, consequently it was possible to identify in advance which nurses would be on duty the following day, and which patients they were allocated to care for. This system of allocation made it possible to ask the nurses to assess the patient, and complete the observation schedules on the day before the observation was carried out. This was facilitated by the fact that the dependency ratings on this ward were very stable. At the end of the observation the care given was discussed with the nurse.

Where possible, patients allocated to the care of learners were used. As there was rarely more than one learner on duty, a patient would usually be selected from the learner's allocated group of nine patients. Criteria used for selection of the patient were, firstly, that the patient's care had not been observed before. Secondly, in order to observe as many different types of patient as possible, an attempt was made to select a patient that had different problems that were different from patients previously observed on the ward. Occasionally, however, learners were not available to observe as they were not on duty on every shift, therefore other nurses working on the ward were also asked to participate. Again, an attempt was made to diversify the data collected.

The allocation of nurses to the same group of patients for a whole week therefore greatly facilitated data collection on this ward. However, even given this arrangement, problems were still encountered. Firstly, there appeared to be some discrepancy between the learner's knowledge of the patient's care needs, and the knowledge of the qualified staff on the ward. For the purposes of completing the observation schedules, it became necessary to involve both a member of the qualified staff and the learner nurse.

Secondly, it was found to take anything up to three hours to complete the observation schedules on an individual patient. It never took less than an hour. The schedules identified aims of care with which the nurses agreed, however, much of the care required to implement these aims was not normally given, therefore they created considerable discussion. This discussion included suggestions as to how these aims could be met, and reasons as to why they were currently not being met. This clearly provided very valuable data which are used in the analysis of care given in the Chapters Six and Seven.

Completing the observation schedules meant taking two nurses off the ward for between one and three hours every day. While the nurses did not object to this, it was possible that such a lengthy process would interfere with the normal working of the ward, and therefore the data collected would not reflect the normal organisation of care which the researcher intended to observe. Throughout the observation on all three wards this problem created a considerable

dilemma which was never satisfactorily resolved. It also highlights the fact that planning care to incorporate diverse and incompatible health care models is a lengthy and time consuming process, which does have implications for staffing levels if it is to become an important part of the care given to every patient, and if the plans are to be regularly reviewed.

Data Collection on the Medical Ward

The medical ward was the second ward observed. Experience on the geriatric ward indicated the lengthy process involved if the nurses were to participate fully in the research. Moreover, on the medical ward it was not possible to identify which nurses would be allocated to care for which patients in advance of data collection, as allocation was undertaken on a daily basis (see Chapter Four).

It was necessary, for the purposes of observation, to have the assessment of the patient being observed completed at the beginning of the shift, otherwise the appropriate observation schedules could not be identified. However, it was not possible to to ask the nurses allocated to care for the patient to complete the assessment at the beginning of the shift, as frequently they had not nursed the patient before, and therefore lacked the necessary knowledge. This situation was in part derived from the high turnover of patients on this ward, (as demonstrated in the HAA data given in Chapter Four), and the difficulties experienced in

maintaining continuity in the allocation of nurses to patients.

On days used for general observation, the researcher asked the nurses to complete assessments on all the patients in their group. The following day a patient was selected for observation from a group to which a learner nurse was allocated. Often the nurses giving care to the patient on the day of observation were not the same nurses as those who completed the assessment. Therefore, the researcher had to accept the possibility that those implementing the care might assess the patient differently, and consequently give a different level of care to that indicated by the assessment undertaken by a different nurse on the previous shift. Moreover, it was also possible that the dependency level may have changed. However, this reflects the reality of the current organisation of care, and is endorsed in most of the nursing process literature (Kratz 1979, Hunt and Marks-Maran 1980, Barnett 1982), which suggests that qualified staff can assess and plan in advance patient care, which is then implemented by other staff. In fact, when the nurses observed to give care were asked, at the end of the shift, to complete a second assessment on the patient being observed, it was found to correspond closely to the original assessment.

Partly because of the above allocation process, considerable problems were experienced in asking the nurses to complete

the observation schedules. While the qualified staff were very supportive of the research, the problem of the time it took to accomplish this aspect of the data collection was much more acute on this ward. When qualified staff did participate they were frequently called away before they had finished. Without the overt support of the qualified staff, learners appeared reluctant to give the time necessary to participate, as it took them away from the work of the ward. When they did participate, the aims of care they selected from the observation schedules tended to directly reflect the care they were observed to give.

Agency Nurse Participation in the Research

Asking the nurses to participate in data collection involved lengthy explanations about the research, and the reasons why it was being conducted. The nurse then had to be introduced to the nursing assessment and observation schedules, and given a detailed explanation as to what was required. This took up a considerable amount of both the nurse's and the researcher's time.

The high use of agency staff on this ward meant that it was frequently necessary to ask these nurses to take part. Occasionally they were able to find the time to complete both the assessment and the observation schedules. However, throughout the observation the researcher was faced with the dilemma of getting the schedules completed by the nurses giving care, and risking missing important aspects of the

care being given. This problem was particularly acute with agency nurses. The fact that they only worked for one or two shifts on the ward meant that the researcher was aware that time invested in informing them about the research would only have benefits for the duration of the shift. Therefore, the cost, in terms of time spent, had to be evaluated against the extent to which the nurse would be involved in future data collection, and with agency nurses their potential participation was extremely limited.

As a result of these problems on this ward, the researcher often simply observed and recorded the care given on the basis of the assessment under the appropriate activities of living.

Data Collection on the Surgical Ward

The surgical ward was the last ward to be observed. The use of team nursing meant that it was possible to identify in advance nurses who would be allocated to care for the patient under observation (the system of patient allocation used is described in Chapter Four). However, on this ward, the patients level of dependency changed more rapidly than on the other two wards, as a result of premedication and surgery. Therefore, it was necessary to ensure that the nursing assessment on the patient to be observed was carried out on the day of observation. Frequently the pressure of work made it difficult for the nurses to do this at the beginning of the shift. Consequently, many of the nurses

completed the assessment and observation schedules at their own convenience during the course of the shift. Occasionally this meant that they were completed retrospectively at the end of the shift.

In order to accommodate this problem, observations of the care given were recorded under the heading of each of the activities of living. These were then matched with the assessment and completed observation schedules. The care given was discussed with the nurses and agreement reached as to which of the aims was met by each aspect of care given.

The qualified staff were able to participate more on this ward, and did not tend to be interrupted quite so much. Consequently, the learners seemed more confident about becoming involved. Moreover, this particular method of data collection considerably reduced the time taken by the nurses to complete this aspect of the research, and this in itself probably helped to increase the level of participation.

Again, it was difficult to include bank and agency staff in the research for the same reasons as experienced on the medical ward. However, these nurses were frequently used to provide qualified cover on teams for which only learners were on duty. Therefore, in order to observe patients cared for by learners, agency and bank nurses were frequently involved. Patients being cared for by agency and bank staff were included, but for these patients only the assessment was undertaken by the nurses giving care, and, except in one

case, the aims of care were not directly identified by these nurses.

CONCLUSION

This chapter identified the difficulties encountered with data collection and the modifications that had to be made on each of the three wards in the light of the adhoc and ever-changing staffing structure which characterised each ward. It highlights the problems of introducing aims of care which reflect a range of different health care models as in order to conform to the methodological requirements of the research, the nurses needed to be able to assess patients, negotiate goals of care, use judgement to select specific aims of care and finally to implement those aims within the ward environment. It was found that learners, agency, and bank nurses lacked the knowledge about the patient that was necessary to complete this process. Qualified staff were able to assess and plan care but lacked the time required to fully consider each of the aims and to identify how the aims which were selected, could be implemented. Moreover, the high turnover of patients on the medical and surgical ward, the rapid changes in dependency which characterised the surgical ward, coupled with the difficulties both these wards experienced in maintaining continuity in the allocation of nurses to patients, meant that qualified staff frequently experienced difficulty identifying aims of care in advance of the need for implementation.

As described above, the data collection was modified on each ward to take account of these difficulties. Table Seventeen indicates that, on the medical ward, very few nurses took part in selecting aims of care from the observation schedules and planning their implementation. On the surgical ward, however, this process was completed concurrently, and, in some cases retrospectively. This clearly contradicts all texts on the nursing process, which maintain that assessment and planning should take place prior to implementation. However, it highlights the conceptual and practical problems nurses are likely to encounter when attempting to practice individualised care in an environment which has evolved to accommodate the prescriptive practices associated with the medical model.

The difficulties encountered with data collection meant that other sources for the completion of the observation schedules were used. In particular, use was made of the ward report, since this was the main method used on each ward to identify the care needs of patients. Any information on the patient to be observed given during the report, was noted down and incorporated on any observation schedule finally used, under the appropriate heading.

As a result of the problems with data collection discussed above, the nurses shown in Table Seventeen participated in the research from each ward. The data described in this

chapter, form the basis of the observational stage of the research. The findings of this stage of the research are presented in the next chapter.

TABLE SEVENTEEN
NURSES PARTICIPATING IN IDENTIFYING THE AIMS Of CARE BY DEPENDENCY ON ALL THREE WARDS

	DEPENDENCY LEVEL		
	HIGH	MEDIUM	LOW
GERIATRIC WARD			
Total number of patients observed.	1	6	2
Grade of nurse participating in research.	3rd yr.STN	EN 1st yr.PN SN 1st yr.PN SN & PN EN	EN SN
MEDICAL WARD			
Total number of patients observed.	3	7	6
Grade of nurse participating in research.	EN N/P x 2	EN 3rd yr.STN 3rd yr.STN N/P x 4	3rd yr.STN AGSN N/P x 4
SURGICAL WARD			
Total number of patients observed.	1	11	4
Grade of nurse participating in research.	SN	SN X 2 EN 3rd yr.STN 2nd yr.PN *ASN AEN N/P x 4	3rd yr.STN 3rd yr.STN N/P x 2
Total No. patients	5	24	12
Total Nurse participation	3	16	6

KEY:- N/P = Care observed but nurses giving care did not participate in identifying the Delphi aims of care.
* = Agency Staff nurse working full time on the ward
SN = Staff Nurse
EN = Enrolled Nurse
STN = Student Nurse
PN = Pupil Nurse
ASN = Agency Staff Nurse
AEN = Agency Enrolled Nurse

Chapter Six

The Findings From The Observational Study

Introduction

This chapter presents the findings of the observational stage of the research, the results of the Delphi survey being used to structure the collection of these data. The Delphi survey results also provided the framework for categorising the data and is used to organise the presentation of the findings in this chapter.

CATEGORISING AND PRESENTING THE OBSERVATIONAL DATA

Chapter Three, which presented the results of the Delphi survey, concluded with the development of a working hypothesis or proposition, about nursing, which was derived from the survey. This proposition suggested that nursing is currently characterised by a lack of consensus about the aims of care and that nurses have in practice to mediate between these aims in the implementation of care.

In the light of this proposition the observation focused on identifying where the locus of control in setting the aims of care for basic nursing, resided for individual patients on each ward. Since this research was primarily concerned with the role of the learner nurse, the above proposition suggested the need to identify the types of decisions about care, taken by learner nurses, and to consider to what extent the decisions taken by learners contributed to the implementation of individualised care.

The categorisation of the data collected during the observational stage of the research reflected the above questions and was therefore, classified under the following headings:-

1.What decisions did nurses take about care?

2.Which grades of staff took these decisions?

3.Which grades of staff implemented these decisions?

The analysis of the results of the Delphi survey, given in Chapter Three, highlighted that control over decision making can rest primarily with the medical staff, or with the nursing staff, or with the patient. This framework, suggested that a number of different definitions of individualised care currently co-exist within nursing. As described in Chapter Three individualised care can be interpreted as a method of care which enables the patient to identify their own aims of care. In this case the work of professionals is limited to facilitating the implementation of these aims. The results of the Delphi survey also suggested that a second framework for identifying the aims of care for basic nursing exists. This locates control over the aims of care with the nurses and gives rise to aims which are described as rehabilitative, since they seek to promote adaptation in the patient to fit a nursing definition of independence, without ascertaining whether the patient shares this definition. The aims of care reflecting the two frameworks are presented in Tables Five and Six in

Chapter Three.

This framework was adapted and used to categorise the observational data. As suggested in Chapter Three, it focuses attention on whether decisions about the care needs of patients are located primarily with the patient or with the nursing staff. Decisions that are located with the nursing staff can be further classified into decisions taken by different grades of staff. In this research this is broken down into decisions taken by qualified staff and those taken by learners.

Because the observational schedules which were derived from the Delphi survey, reflected the basic care needs of patients, the findings are obviously dominated by this aspect of care. However all aspects of the care given to the patients under observation, were noted down and some discussion of technical care is therefore also included. The initial categorisation of the observational data indicated that very few explicit nursing decisions were taken about basic nursing care. The first section of this chapter describes how basic care was implemented on each of the three wards.

As discussed in the previous chapter the observational schedules were introduced in order to help the nurses make more explicit their decisions about the aims of basic nursing care. A description of the nurses' interpretation of the observational schedules and the problems they identified

with some of the aims of care contained in the schedules, forms the second section of this chapter.

From the initial categorisation of the data it became apparent that, although few explicit decisions were taken to individualise the basic care needs of patients, numerous examples of individualised decision making about technical care were observed. These findings are presented in the third section of this chapter.

Finally, a few examples of decision making by learner nurses were observed. These incidents are important as they highlight the situations and circumstances in which learner nurses adopted a more proactive role in determining the care needs of patients. Such incidents are presented in the final section of this chapter.

THE IMPLEMENTATION OF BASIC CARE ON EACH OF THE THREE WARDS

As discussed earlier, on all three wards the ward report was used as the main method of identifying the care needs of patients and delegating the care to be given. Therefore, an analysis of the information given at the report to the nurses about the nursing needs of the 42 patients observed, was undertaken. This revealed that the major factor determining the organisation of care given was the individual patient's level of mobility.

Of the 16 patients observed on the medical ward, in all but one case the patient's level of mobility was given at the

report. Of 17 patients observed on the surgical ward, the patient's level of mobility was directly given in 5 cases and indirectly referred to in 12 cases. Of these 12 cases, in 3 cases the nurses were informed that the patient was for discharge that day, which on this ward implied that the patient was fully mobile. In another 3 cases the nurses were informed that the patient was prepared for theatre and had been given premedication. In 6 cases the nurses were informed that it was the patients first post-operative day following major abdominal surgery; on this ward all patients were sat out of bed on the first post-operative day following major surgery.

Information given on the patients level of mobility can be contrasted with information given on the other five activities of living included in the nursing assessment. These are hygiene, dressing, elimination, nutrition and communication. Of the 16 patients observed on the medical ward, information relating to any of these other activities of living was given on 10 patients. Of the 17 patients observed on the surgical ward, information relating to any of these other activities of living was observed to be given on 9 patients.

The geriatric ward had a very stable patient population. With a few exceptions, the condition of patients on this ward did not change markedly from day to day. Therefore, the nurses giving the report tended to assume the nurses coming on duty knew the condition and abilities of the patient.

Consequently, only unusual incidents or sudden changes in behaviour or condition were reported.

The analysis of information given about mobility as against any of the other activities of living, highlights the importance of the patient's ability in this area as a factor around which care is organised. As the analysis given below illustrates, the patient's level of mobility was found to be an indicator used by the nurses giving care, to determine the patient's care needs in a range of areas including hygiene, elimination and prevention of pressure sores, as well as mobility itself.

Identifying the Care Needs Of Patients For Mobilisation

Data collected on medium and high dependency patients on all three wards indicates that on none of these wards was mobilisation seen as a discrete aspect of care. On every ward when care was given in order to promote mobilisation, it was invariably undertaken in conjunction with some other aspect of care, in particular meeting the hygiene and toileting needs of the patient. Therefore, an analysis of the care given to mobilise patients will proceed through an analysis of the care given in these two activities of living.

Meeting the Hygiene Needs of the Patient

The hygiene needs of patients tended to be differentiated according to whether they were on bedrest or able to sit out in a chair. Patients on bedrest were usually given a blanket

bath, while those who could sit out in a chair were given a bowl and help with a wash. This pattern was observed to occur on every ward.

An analysis of the instructions given at report indicated that of the 11 medium and high dependency patients observed on the medical ward, specific instructions regarding hygiene were only given on 4 patients. Of the 13 medium and high dependency patients observed on the surgical ward, on only one occasion was hygiene care referred to at report. For the reasons given above, no information was usually given in relation to this aspect of care on the geriatric ward.

The aims of care for hygiene for medium and high dependency patients, as identified in the observation schedules are given in Appendix E . This indicates that patients falling into these two categories of dependency can range from those that need very little help, to those who need assistance because of physical restriction, (eg. by an intravenous infusion), through to those who are in need of rehabilitation as a result of physical incapacity, to those who need total care. It would appear, therefore, that without further information, the nurse giving care, who could be an auxiliary, learner, agency, or permanent qualified nurse, had to identify the level of help required by the patient.

In practice it was observed that each ward operated a routine for this aspect of care that promoted the aims of

care thought by the nurses to be particularly relevant to the needs of the patients on that ward. Therefore, these aims differed from ward to ward, according to the patient characteristics found to be dominant for each dependency grouping on each ward.

Meeting Patients' Hygiene Needs On The Medical Ward

On the medical ward, active rehabilitation of patients was seen by the nurses as an aim of care for all patients who were able to sit out in a chair but who were unable to walk to the washroom. These patients were given a bowl and left to manage as far as they could themselves. The nurses then returned to the patient to see how well they had coped, any assistance required was then identified and given. It would appear that this routine allowed the patient to determine their own level of independence. Those who were totally independent could complete the care themselves. On returning to the patients, those who could not manage would be identified, and assistance given. Active rehabilitation was interpreted as giving the patient the opportunity to wash independently, followed by giving any assistance required.

This theme is illustrated in by the following incidents:-

On one occasion an enrolled nurse on the medical ward instructed a student nurse to leave a patient to manage by himself for a few minutes, and then to give any assistance required.

Similarly, on another occasion a staff nurse on the medical ward was distributing bowls to each of the patients in the acute bay. She identified two patients

who would not be able to manage by themselves. She still gave each patient a bowl, and told them assistance would be forthcoming. She then asked a student nurse to go and assist both patients. This meant one had to wait while the other was attended to.

Meeting Patients' Hygiene Needs On The Geriatric Ward

The hygiene care given on the geriatric ward was subject to a similar routine. Table Eighteen is a breakdown of the mobility, orientation, and control of continence of 35 patients on the geriatric ward at the time of the research. It is based on the nursing assessments undertaken by the nurses using the assessment developed by Hunt (1982) given in Appendix G.

TABLE EIGHTEEN
ANALYSIS OF THE MOBILITY CONTINENCE AND ORIENTATION OF 35 PATIENTS ON THE GERIATRIC WARD

	Urinary Continence	
Level of Mobility	Continent	Incontinent
Fully Mobile Alert and Orientated	5	0
Fully Mobile Confused	0	2
Walks with Assistance Alert and Orientated	2	2
Walks with Assistance Confused	0	4
Chairbound Alert and Orientated	4	5
Chairbound Confused	0	10

On this ward the nurses aimed to get all the patients out of bed, put on the commode, and washed and dressed, in time for breakfast, which was served by the housekeeping staff at 8.30 am. The night staff usually washed and dressed some of the patients before they went off-duty. As the analysis of the staffing structure illustrated, there were usually 5 nurses on a morning shift. Four of the nurses would have a group of up to 9 heavily dependent patients to care for. They would be assisted by the fifth nurse, usually the auxiliary, who would float.

Nearly all the patients on this ward, including the majority of patients who could walk, required two, and in some cases, three nurses to stand or walk them. Therefore, the nurses were constantly calling each other to help with lifting. On this ward the actual washing and dressing of the patient was undertaken by the nurse allocated to care for the patient, but she was frequently interrupted to help with other patients and delayed while she waited for assistance. To keep the delay to a minimum the nurses usually prepared several patients, so that they could help one patient with the aspects of care that could be carried out by one nurse, while waiting for assistance with the other patients. This activity was, however, frequently interrupted, as she was called to assist nurses caring for other groups of patients. On one occasion a student nurse was observed to ignore a confused patient's call for help with dressing, and continued to clear used commodes from the centre of the

ward. The student nurse had earlier completed an observation schedule on which she had written "remove all used commodes from the ward before breakfast is served". At the time of the observation the housekeeping staff had started to serve breakfast. This illustrates that the constant interruptions, the need to avoid delay in waiting for assistance and the pressure to get the care given before the breakfasts arrived overrode any aims for rehabilitation the nurses may have planned for the patient.

Meeting Patients' Hygiene Needs On The Surgical Ward

On the surgical ward, instructions about the care needs of patients were related to the progress they were expected to make by both the surgeons and the qualified nurses, following surgery. Patients who had undergone major abdominal surgery with wound drains, an intravenous infusion, and a urinary catheter in-situ, were given a blanket bath and sat out in a chair for bedmaking only on the morning of the first post-operative day.

In the evening they were walked out to the washroom and given a wash, usually they were not left during this procedure. On the second post-operative morning, following instructions from the surgical team, it was usual for wound drains, urinary catheters and intravenous infusions to be removed. Once these were removed the patient was given a bath, and then allowed to mobilise as fully as possible.

This was the observed post-operative routine on this ward

and appeared to apply to all patients who had undergone major abdominal surgery, regardless of their underlying level of fitness. For instance, on one occasion a patient who was obese, had a history of thrombosis, and was a diabetic, was subjected to the same post-operative hygiene routine as patients who were younger and fitter than herself. At the end of her first post-operative bath she complained of pain and exhaustion, which none of the other patients appeared to experience. Instructions which outlined the above routine were frequently given by the qualified nurses who worked permanently on the ward to the junior nurses as they were implementing care. Like the medical ward, the care given on the surgical ward facilitated the post-operative aim of care, which was to mobilise the patients. However, in meeting this aim, the nurses did not differentiate between the care needs of patients for hygiene. Instead, each patient was subject to the same routine.

Deviations from the Hygiene Routine

Very few deviations from the hygiene routine were observed. Occasionally the qualified staff would attempt to individualise care by giving instructions for a particular patient which differed from the routine. The situations in which this occurred are discussed below on pages 234 and 235. The lack of instructions from qualified staff could, however, give rise to different interpretations by transient staff, of the care needs of a specific patient. On one

occasion on the medical ward, a patient suffering from a Cerebral Vascular Accident with hemiplegia was given a bowl and left to manage her own wash according to the normal routine. This she succeeded in doing. The nurse in question was called away to assist with the drug round. The following day the same patient was given a wash fully assisted by a different nurse. Both the nurses involved were agency staff nurses. Neither of the nurses had been given specific instructions about the care needs of the patient with regard to hygiene.

Meeting the Needs of Patients for Urinary and Faecal Elimination

The above analysis indicates that on each ward certain patient characteristics are found to dominate each dependency level, and the aims of care incorporated in the routine used on each ward are derived from these characteristics. This was also found to be the case for urinary and faecal elimination.

Patients who were confined to bed, or whose mobility was confined to sitting in a chair, required assistance in gaining access to toilet facilities. On the medical ward, patients on bedrest were invariably also catheterised, as they tended to be high dependency patients who were usually either confused or unconscious, and therefore liable to incontinence. On the surgical ward, the only patients on bedrest for any length of time had undergone major abdominal surgery during which they were catheterised. As described

above, they began mobilising following the removal of the catheter.

On both the medical and surgical ward, patients whose mobility was restricted to sitting in a chair were usually given a call bell, and were able to contact the nurse when they required the toilet. This reflected the fact that most of the patients observed on these two wards who could sit in a chair, were able to identify when they needed to use the toilet. The only time patients were offered access to the toilet was when regular urinalysis was required, i.e. in the case of a patient with diabetes. This routine can be contrasted with the toileting routine on the geriatric ward.

On the geriatric ward, as Table Eighteen, illustrates 4 chairbound patients who were alert and orientated were not incontinent. These patients were able to attract the nurses attention when they needed to use the toilet, and so maintain their continence. Five patients who were also alert and orientated but chairbound were, however, occasionally incontinent.

The aims of care as defined in the survey, indicated that control of incontinence requires these patients to be toileted regularly, in order to reduce the incidence of incontinence, and perhaps retrain the bladder. On this ward all the incontinent patients were put on the toilet every 2 - 3 hours throughout the day. This enabled this aim to be met for the majority of the patients. However, the numbers

involved meant that this care took the form of toilet rounds. Therefore, again, the aims of care can be seen to be incorporated into the routine. It had the disadvantage that patients who were alert and orientated, and who could control their continence frequently had to wait their turn in the queue that occurred during these rounds. This was observed to create considerable distress for these patients.

Similar differences were observed between the medical and surgical wards and the geriatric ward in relation to faecal elimination. On the geriatric ward, a bowel chart was kept in the front of the kardex. Every time a patient had their bowels opened, it was recorded on the chart. This reflected the fact that the majority of patients on this ward would not be aware of the fact that they may be constipated. Constipation is a recognised problem among elderly patients, aggravated on this ward by the lack of mobility of these patients. Therefore, the risk of constipation was high. The nurses needed to be able to identify which patients appeared to be getting constipated, so that preventive action could be taken. The bowel chart enabled them to do this quickly and effectively.

On the medical and surgical ward no such chart was kept. This reflects the fact that the majority of patients on these wards were able to inform the nurses if they thought they were suffering from constipation. However, not all patients were able to do this. On the medical ward an elderly confused patient suffering from urinary incontinence

was admitted. His urinary incontinence was successfully controlled by the use of a urinary sheath. However he was not observed to receive any assessment of the state of his bowels, as this fell outside the normal routine for care on this ward. Care was not given until the problem became visible in the form of faecal incontinence. Preventive care was not instigated in this case, as it was on the geriatric ward, because the ward staff relied on the patients being able to inform them if they were becoming constipated, and therefore this aspect of care was not routinely assessed.

Pressure Area Care

On all three wards patients under observation, who were classified as on bedrest, were turned regularly, in order to prevent the development of pressure sores. This was monitored by the nurse in charge. The care given to patients on bedrest to prevent the development of pressure sores, can be contrasted with the care given to patients whose mobility was limited to sitting in a chair. On all three wards patients, whose mobility was limited to sitting in a chair were not observed to receive active pressure area care independently from other aspects of care. On all three wards pressure area care was observed to be given to these patients, when the patients were washed on the medical and surgical ward, and when they were washed and toileted on the geriatric ward. On all three wards washing was carried out twice a day. Some of the patients on the medical and surgical ward also had pressure relieved when they used the

commode. However, not all patients used the commode, surgical patients that were catheterised did not, and neither did male medical patients who used a urinal.

On the medical and surgical ward, patients were immobilised for relatively short periods of time during the acute phase of their illness, and this in itself probably protected them from the development of pressure sores. On the geriatric ward, only two patients were catheterised. The remaining patients were transferred to the toilet or commode every two to three hours as part of the ward routine. This seemed to provide sufficient pressure area care as none of the patients on this ward appeared to have pressure sores, despite their low level of mobility. Two patients were, however, reported to have signs of pressure sore development, but no extra care was given.

THE NURSES' INTERPRETATION OF THE OBSERVATION SCHEDULES

The routinised approach to basic care described above, can be contrasted with the nurses' interpretation of the aims of care contained in the observation schedules. When discussing the care given to specific patients with the nurses, and in analysing the completed observation schedules, it became clear that a discrepancy existed between generalised discussions about care, and the aims of care identified by the nurses in relation to a specific patient. When completing the schedules the nurses were asked to identify aims of care in relation to care giving for that shift. This

considerably narrowed the range of aims thought appropriate by the nurses when completing the schedules. For instance, if the patient was still under the effects of an anaesthetic the aims of care relating to control over the illness were frequently considered inappropriate. The nurses, therefore, would dismiss choices over food, hygiene, dressing, and even information as not relevant to the needs of the patient during that shift.

The aims of care identified as necessary in the schedules very much reflected the contextualised situation in which care was given. Analysing these aims highlighted the difficulties of comparing generalised, and therefore idealised, notions about practice, with the aims selected in relation to actual care situations, particularly as the nurses were aware that the completion of the schedules was linked to observation of practice. As a result, they tended to leave blank aims which they identified verbally as problematic for this patient, but felt they could not implement. Conversations with the nurses suggested that some of the aims, particularly those outlined in Table Five, did present difficulties, as it forced them to reflect on the discrepancies between their own idealised notions of nursing, and the realities of their own practice. This discrepancy was found to be greatest on the long stay geriatric ward. On both the medical and surgical ward, the temporary nature of the illness, and transient admission to hospital for treatment, meant that the nurses on these two

wards did not feel that the aims outlined in Table Five were quite so important for these patients, and that other priorities dominated. If, however, the nurses did identify aims of care derived from Table Five, they tended to explain their failure to implement them in terms of their interpretation of the structural organisation of the ancillary services which supported these aspects of care.

Structural Constraints on the Promotion of Patient Autonomy

Many of the aims given in Table Five indicate the need to give patients control over how their care needs are met. This was, in fact, felt to be quite important by the nurses on each of the three wards, though the areas in which the nurses considered it appropriate for the patients to exercise control differed from ward to ward. For instance, the sister on the geriatric ward felt that the patients should be given a control over diet, as well as mealtimes. She also thought that patients should be given a choice about the clothes they wore. On the medical and surgical ward choice about clothes worn and the times of meals were seen as less important; as the patients were acutely ill and this was only a temporary disruption in their lives, their autonomy in these areas would return when they were discharged.

However, on both the medical and surgical wards the nurses thought the patients should be given a choice about the food they ate. For patients who were considered capable of making

a choice, and whose diet was not determined by the therapeutic regime, (i.e. not nil by mouth), all the nurses who completed the schedules on these two wards, ticked choice of food as an aim of nursing care. However, only one nurse on the medical ward ticked choice over time of meal as an aim. This was for a low dependency patient, whose relatives were already supplying his food.

The extent to which patients could exercise choice in relation to diet, mealtimes, and clothes worn, was determined primarily by the structural organisation of catering and laundry services within each hospital. On the medical and surgical wards, a plated meal service was in operation. This utilised a menu system which had to be completed three days in advance of a given meal. If a full complement of meals were ordered, then it was difficult to change the orders, even though patients may have been discharged and others admitted. The high turnover of patients particularly on the medical ward, meant that for a large number of patients this aim could not be met. These problems were regularly reported to senior management with little effect. Moreover, there were no facilities in the new hospital for storing and cooking food on the ward.

On the geriatric ward, meals were served at set times each day by the housekeeping staff. Food was sent up on a trolley and the patients were given a choice from the trolley. Concern had been expressed by senior management about the delegation of nutritional care to housekeeping staff, as a

result, they suggested that the housekeeping staff should be supervised by the nursing staff. There were, however, only a very few occasions when this was observed to happen. Between 5 and 6 patients needed feeding every mealtime. There was rarely more than 5 nurses on duty. Frequently, the nurses were engaged in attempting to complete the last toilet round or the drug round ahead of the meal trolley, and greater priority was given to getting every patient off the toilet than to supervising meals. Moreover, the housekeeping staff were consistently observed to offer patients a choice of food from the trolley. Many of the patients used specially adapted plates and knives and forks, and the housekeeping staff were familiar with the patients and knew which patients used this equipment.

The aim of a choice about mealtimes and the opportunity of staying in bed until breakfast, desired by the sister, was, however, found to be difficult to achieve. Mealtimes were largely determined by the catering department. Although there were facilities for keeping food hot on the ward, the food trolley had to be returned to the catering department by a certain time after every meal. The housekeeping staff felt that failure to return the trolley by the stated time would be interpreted as inefficiency on their part by their manager. Therefore, the extent to which the nurses could offer a choice of mealtimes was limited. The set mealtimes were seen as a constraint by the nurses, within which they had to work. It was not something that they considered it

within their power to alter, and therefore they made no attempt to negotiate with the catering staff more flexible arrangements for mealtimes.

The nurses on the geriatric ward also stressed patients should be given a choice about the clothes they wore, and that the clothes should fit well. There were no laundry facilities for personal clothing at the hospital, therefore many patients were dependent on hospital clothing. There was frequently a shortage of clothes and the nurses had to dress the patients in whatever was available. On one occasion the patient under observation complained about being dressed in trousers. The student nurse explained that no other clothes were available. In identifying the aims for this patient the student nurse had written, "give the patient a choice of clothes at all times".

Giving Patients a Choice about Hygiene Needs

The ward routine for meeting patients' hygiene needs on each ward is described above. On all three wards the nurses suggested that it was important to give patients a choice about when and how their hygiene needs were met. Choice appeared to vary according to dependency. It was emphasised more for medium and high dependency patients on the geriatric ward than on the medical and surgical ward. For instance, 5 out of 7 nurses suggested that a specific medium or high dependency patient should have control over their hygiene routine on the geriatric ward, while only 1 out of 6

nurses identified this as a specific aim for a given patient on the surgical ward. 6 out of 7 nurses on the geriatric ward identified the promotion of independence in meeting hygiene needs as an appropriate aim for the patient under observation, while no nurses identified this as an aim on the surgical ward. However, this reflects the temporary nature of dependency on the surgical ward, and the fact that independence was regained following the removal of the patients' intravenous infusion and wound drain. This moved the patient into a low dependency category which meant they were able to exercise complete control over their own hygiene.

On the medical and surgical wards the nurses did discuss the care to be given with the patients, but opportunities for choice within the discussion were limited, instead the patients were informed about the routine care they could expect to receive. It was interesting to observe, however, that the patients themselves tended to reinforce this routine. On both the medical and surgical wards patients with similar dependency levels tended to be put in the same bay, to aid observation and access to facilities such as piped oxygen and suction equipment. The patients were observed to discuss together the progress they were making. As soon as a patient became fully mobile they were moved out of the acute bays into the side bays (see Appendix F). Therefore mobilisation was linked to independence and discharge. However, as discussed above, it was also linked

to hygiene, and it is possible that the patients themselves thought it important to adhere to the hygiene routine in order to feel that they were making satisfactory progress towards discharge.

The Need to Help Patients Adapt to Illness

It was stated in the last chapter that one of the problems confronting the researcher, in asking the nurses to complete the observation schedule, was identifying which nurse to ask. On the geriatric ward learner nurses were allocated to care for a group of patients for a week. However, it soon became apparent that they lacked detailed background knowledge about the patient and that this limited the extent to which they were able to identify the nursing needs of the patient.

Frequently, discussion with the sister identified a range of problems unknown to the learner nurse allocated to care for the patient. Many of these problems were derived from the circumstances surrounding the admission of the patient some months or even years before the learner arrived on the ward. These problems were often related to the future accommodation of the patient. A number of patients on this ward had been assessed as being "at risk" if they were discharged home. This problem was exacerbated by the fact that some of these patients lived in rural parts of the District and were cut off in winter, therefore social services could not be maintained and the patient could risk developing hypothermia or dehydration. A number of these

patients had, however, been assessed as suitable for social service accommodation, (see Appendix L) but some were reluctant to move as this meant they had to give up their home. Consequently, they chose to stay in hospital and maintain the possibility that they might one day be discharged home, a possibility that would be denied if they accepted transfer to social service accommodation.

It could be argued that problems such as these do not impinge directly on the daily physical care needs of these patients. However, they do provide a context for any care plan. This knowledge could be used by the nurses giving care to identify incentives for the patient to work at physical rehabilitation, and as a basis for negotiating the goals of care with patients. It also enables the nurses to discuss with the patient the range of possibilities open to them, and perhaps help the patient to adjust to the physical and mental incapacities arising from the illness. This is illustrated in the following case study which highlights the process of dependency that can ensue from a failure to recognise and accommodate patients' own choices.

> During the course of the research a patient was admitted to the geriatric ward following assessment on a rehabilitation ward. On admission she stated that she wanted to go home. She lived in an isolated rural part of the county, and both the medical staff and her relatives felt that she was "at risk" if she was discharged, as she lived by herself. This was thought to be a particular problem in winter as frequently the roads were blocked, and Social Services could not maintain services.
>
> On admission, the patient was observed to be fully mobile using a zimmer frame. She was slightly

disorientated and scored 1 for communication and 1 for sociability on the nursing assessment (see Appendix D). Shortly after admission she became very agitated and demanded to go home. The nurses explained that this was not possible. The patient insisted and started trying to leave the ward. At the time this incident was observed there was an enrolled nurse in charge of the ward, a first year pupil nurse, and an auxiliary on duty. The auxiliary held both the ward doors closed for about half an hour in order to prevent the patient getting out. The enrolled nurse spent this time trying to persuade the patient to stay. The patient refused. Eventually the nurses removed the zimmer frame and wheeled the patient back to bed in a wheelchair.

This situation was repeated several times over the next few days. Whenever possible the relatives were contacted by phone, and they would try to persuade the patient to stay, occasionally with some success. However, before long the patient would again become agitated. Eventually the patient refused to walk, even when encouraged by the nurses and occupational therapists. The patient said that if she had to stay in the ward she expected to be waited on like all the other patients. By the time the research was completed on this ward a few weeks later, the patient was both incontinent and immobile.

In every case when completing the observation schedules the nurses stressed the importance of helping the patient to come to terms with the illness. This was prompted by the aim "enable the patient gain control over the illness". The discussion of this aim usually resulted in the learner nurses finding out more about the patients background and reasons for admission. However, in every case the learner nurses expressed anxiety about this aim. They were not sure how to discuss with the patient their current situation and future plans. As one pupil nurse said, it might depress the patient and she didn't want to do this. Another student nurse changed her mind about this aim when she realised she didn't know how to implement it. More importantly perhaps,

was the fact that although the permanent qualified staff possessed this knowledge they did not include it in the care they planned, or implemented for these patients. This knowledge was not integrated into the care of the patient and the problem remained unresolved, often for many years. It would appear that although all the nurses, both qualified and unqualified, recognised the need to help patients adapt to the physical and social consequences of their illness, they lacked an understanding of how to do this.

NON-ROUTINISED DECISION MAKING OBSERVED ON EACH WARD

Numerous examples of non-routine decisions initiated by nurses were observed. They included such things as, the decision to refer a patient to a dietitian following a diagnoses of diabetes, the decision to refer a patient to physiotherapy, the decision to restrict a patients fluid intake because the patient was vomiting following surgery, the decision to fan a patient who had a temperature, the decision to give analgesia and antiemetics to post-operative patients, the decision to give oxygen to a patient suffering from chronic lung disease, and, as the following case studies illustrate counselling patients and their families.

On two occasions on the gynaecology ward the sister was observed to show patients and their relatives the histology results, contained in the patients' notes, of investigations undertaken to detect cancer. In both cases the sister was aware that the patient and her relatives knew that cancer was suspected. In both cases the results came back negative. At report the sister explained that even when given good results many patients remain suspicious because of the reputation of hospitals in the past not to fully inform patients in

situations such as this. The sister respected the patient's grounds for suspicion and felt that if they were shown their notes, and all the histology results, and had the terminology explained to them, this might go some way towards overcoming the patient's suspicions.

On another occasion the sister on the gynaecology ward spent a considerable amount of time counselling the family of a teenage girl who had had an abortion. She enabled the family to overcome a breakdown in communication about the abortion, which eventually produced a reconciliation between the patient and her parents.

Decision Making By Qualified Staff

While some of these problems were bought to the attention of the permanent qualified nurses on the ward by the learner nurses giving care, in every case the decision as to how the problem should be resolved was taken by qualified nurses working permanently on the ward. A thorough search of the data revealed no examples of learner nurses taking decisions as a result of changes in the patient's condition without first referring to a qualified nurse working permanently on the ward.

More interestingly perhaps, was the fact that it was often the qualified nurses who worked permanently on the ward and in particular the nurse in charge who identified the need for the care in the first place. While the nurse in charge was not directly involved in caring for the patient, she frequently identified that a patient needed care beyond that being given by the nurses looking after the patient, and either instructed the nurses to give the care or gave it herself.

This illustrates that qualified nurses do exercise a considerable amount of autonomy in determining the nursing needs of patients. Moreover, they were frequently observed to take decisions in areas traditionally regarded as the province of the medical staff, such as adjusting fluid intakes, initiating oxygen therapy, and referring patients to paramedical services. In every case they informed the medical staff of their actions, but were not observed to get the initial decision ratified by the doctor before implementing it.

The fact that it was possible to observe numerous examples of decisions which initiated or substantially altered the care given to patients being taken by the qualified nurses who worked permanently on the ward, and in particular by the nurse in charge, suggests that qualified nurses are able to exercise discretion and take decisions to resolve problems emanating from the care of patients. What is interesting is that the decisions observed to be taken by qualified nurses were usually taken in the realm of what is loosely termed medical care, rather than nursing care. There were only four occasions when qualified nurses were observed to make a deliberate attempt to alter the basic care given to patients. These are given below, and, as can be seen, on each occasion they failed.

> On two occasions on the medical ward the nurse in charge specified at report that the patient under observation should be given a full blanket bath before being sat out in a chair. On both occasions the

patient was actually given a bowl and left to manage by themselves. On one occasion the nurse who gave the patient the bowl and left him to wash himself was the staff nurse in charge of the ward who had given the initial instruction that the patient should be given a blanket bath.

On one occasion, on the gynaecology ward, the staff nurse was observed to offer a patient a positive choice between a wash and a bath following the removal of her wound drains and urinary catheter. However she later delegated the care to an auxiliary who approached the patient and told her, that her bath was ready. The patient complied.

Similarly on the geriatric ward a staff nurse instigated passive exercises for a patient. This decision was taken in response to the observation schedule which suggested that an aim of care for chairbound patients should be to prevent the development of contractures (see Appendix E). This patient already had severe contractures of both legs. Passive exercises did not form part of the normal routine for care giving on the ward. As a result of the exercises the patient suffered considerable pain. The exercises were not continued by other members of staff.

These case studies highlight the difficulties qualified staff appear to experience in implementing decisions which alter the basic care routine. It appears, therefore, that while qualified staff are able to exercise discretion in areas which fall outside their professionally defined field of expertise, it was not possible to observe a similar level of decision making in their own field.

DECISION MAKING BY LEARNER NURSES

Explicit decision making about care by learner nurses was rarely observed, however, from the data it was possible to identify a number of occasions when the care given by learner nurses deviated from the routine or from the instructions they had been given by qualified staff. It was

possible to identify two separate situations into which these incidents could be classified. The first was the situation in which the patient requested care that was contrary to the care dictated by the ward routine or the care plan. The second situation arose from the instructions given to the learner nurse by qualified staff. Occasionally a learner, for a variety of reasons, was unable to carry out instructions they had been given. It is suggested that in both these situations the learner nurse was confronted with a dilemma that necessitated a decision.

Decisions Initiated by Patients

A lot of the care observed to be given to patients was initiated by the patient themselves. Patients frequently requested to return to bed after sitting up for some time, or they requested a drink, or to use the toilet. On every ward, as long as the request fell within the routine for that patient, it was met. For instance on the geriatric ward one patient always requested a whiskey with her meals; this was supplied by her relatives, and usually given by the nurses. However, occasionally she demanded more whiskey; this request was usually refused. Similarly, patients on this ward who wanted to smoke were taken to the day room and given their cigarettes. On the medical ward, a patient with a poor appetite asked if his relatives could bring him in food that he could eat when he wanted, as he often was not hungry at mealtimes. Again this request was granted.

However, much of this care depended on the patients to initiate it. For instance patients who were physically unable to transfer themselves to bed and who did not make a positive request to do so, sat up all day. Only those who requested to be returned to bed were returned.

Occasionally, patients requested care that contradicted the ward routine, or specific instructions given by qualified staff. On two occasions on the surgical ward patients declined a post-operative wash. In both cases the wash was not given. In this situation the nurse had to decide whether to adhere to the patients request or implement the ward routine. One of the nurses was a third year student nurse, the other an agency staff nurse.

On another occasion a pupil nurse was instructed by the staff nurse to sit a patient out of bed and walk her at least once round the bed area. The patient was terminally ill and had a chest infection. After only ten minutes of sitting in the chair the patient asked to be put back to bed. The pupil nurse explained that sitting in a chair facilitated lung expansion and suggested that the patient sit up a little longer. She did not help the patient back to bed, neither was she observed to walk the patient as suggested by the staff nurse.

Situations such as those described above present the nurses implementing care with clear choices, as to whether they adhere to instructions, the ward routine, or the care plan,

or whether they allow the patients to decide their own care needs. In adhering to the patients requests the nurses were clearly acknowledging the aims of care set out in Table Five Chapter Three, which locate control with the patient and not the nurse. However, frequently these requests differed from the care planned by the staff nurse, which reflected the aims of care set out in Table Six Chapter Three, which sought to promote aims of care that might be considered therapeutic by the nurses, but not desired by the patient. This illustrates the types of decisions that might confront unqualified nurses in practice, and suggests that the instructions to implement the care plan, cannot always be adhered to.

Decisions Initiated By Difficulties Encountered With The Instructions Given

Occasionally learner nurses were observed to have some difficulty implementing specific instructions they had been given in relation to a particular patients care. In these situations, the difficulty arose, not because the patient objected, but because the nurse lacked the skill or knowledge necessary to implement the instruction.

In one example a first year student nurse on her second ward placement was working under the supervision of an agency staff nurse. Together they had thirteen patients to care for. One of these patients was a diabetic who was recovering from a Cerebral Vascular Accident. The instructions given at report were that this patient was to be mobilised. Because this patient was a diabetic she was on four hourly urinalysis. The student nurse asked the patient for a specimen of urine to test. As discussed earlier mobilisation is not seen as a discrete nursing activity, but is usually combined with meeting the

hygiene and toileting needs of the patient. The student nurse asked the patient how she got to the toilet, the patient did not know. The student nurse asked the agency nurse who replied that the patient was to be walked to the toilet. The student nurse attempted to walk the patient, she was very unsteady on her feet and pulled heavily to one side. The student nurse walked her for a few paces and then tried to use a zimmer frame. Neither the patient or nurse knew how to use a zimmer frame. After a few more paces the student nurse sat the patient down and used a wheelchair to take her to the toilet. No further attempts were made at mobilisation for the remainder of the shift. The patient was due for discharge in a few days, she lived by herself. The ward sister commented that she was concerned about how the patient would manage given that mobilisation had proved unsuccessful. The sister recognised that the patient would benefit from occupational therapy but there were no facilities at this hospital. In her experience it took about three weeks for such a referral to be met. Although the patient was given daily physiotherapy on the ward this only provided instructions to the patient as the sister recognised she required more practice.

This example illustrates the difficulties learners may face in attempting to implement care plans unsupervised. It suggests that skill is required to implement care as well as plan it. It is possible to argue that in the above situation the learner should have sought help. But the agency nurse with whom she was working was busy with a different set of patients. It underlines the point made by the sisters, that they need qualified cover for patients at all times. Moreover it appears to refute the suggestion (McFarlane and Castledine 1982) that learner nurses can work opposite primary nurses on the off-duty. It highlights the constraints within which the ward sisters had to work and makes sense of the sister's suggestion at report that it was "impossible to mobilise this patient".

CONCLUSION

The data presented in this chapter highlight the routinised approach adopted by nurses to the implementation of basic care, but also gives numerous examples of non-routinised approaches to care observed on each of the three wards. It discusses the nurses responses to the observational schedules and the explanations given by the nurses for the care they gave.

The next chapter uses the method of analytical induction, described in Chapter Two, to develop an integrated analysis of the findings from all three stages of the research. This produces a re-interpretation of routinised care which suggests that unqualified and transient nurses control important aspects of the decision making process in nursing.

Chapter Seven

Analysing and Integrating The Research Findings

Introduction

The primary aim of this research which was given at the end of Chapter One, was the identification of the contribution learner nurses make to both the organisation and implementation of patient care. This chapter utilizes the method of analytical induction, described in Chapter Two to address this question. Analytical induction was used in order to develop a framework which would facilitate an analysis and integration of the findings from each stage of the research.

Developing The Framework For Analysis

As discussed in Chapter Two analytical induction is designed to validate the findings of qualitative research by attempting to falsify analytical statements derived from the data. The principles of analytical induction as set out by Denzin (1970) are described in Chapter Two. The ideas underpinning this approach were found to be helpful in categorising and analysing the data collected in this research. In particular the analysis was informed by two major principles associated with analytical induction. The first was the principle of falsification which indicated the importance of attempting to falsify theoretical statements in order to test how representative they are of the whole data set.

This principle was used primarily as an aid in classifying the data. For instance, a theoretical proposition was made early on in the data analysis that ward routines were used to identify the basic nursing care needs of individual patients. Attempts to falsify this proposition gave rise to a separate classification of those situations where individualised care was given in relation to the basic care needs of patients. It highlighted the need to incorporate these situations within the final theoretical analysis of the data.

The second major principle of analysis associated with analytical induction is the need to identify the parameters of a theoretical statement or proposition. This was found to be particularly useful as it focused attention on providing a theoretical interpretation of the data that applied to all three wards. As this chapter indicates the analysis of the routinisation of care observed on each ward could have been grounded in the idiosyncratic characteristics associated with the ward. However, the fact that routinisation was a predominant theme, albeit in a different form, of the care given on all three wards, indicated the need to develop an analysis that was equally applicable to each ward. This was in keeping with the primary aim of the research which was to identify the contribution made to care by learners across all three wards, rather than to identify the specific contribution they made on a particular ward.

It is recognised that the methods of analytical induction as classically described by Denzin (1970) are not fully employed in this research. Nevertheless, those principles of analysis, such as falsification of theoretical statements and the explicit identification of the parameters of a given proposition, which inform the discussion of analytical induction (Silverman 1985), provided a framework which guided the analysis of the research findings.

This chapter begins the process of integrating the findings from all three stages of the research. It starts with a discussion of the routinisation of care observed on each ward and contrasts this with the findings of the Delphi survey and the ward nurses' responses to the survey findings, as set out in the observation schedules. This analysis suggests that routinisation acts as a method of maintaining order on each of the wards. A distinction is, however, drawn between the need for order on the acute wards, and the need for order on the long stay ward.

This chapter goes on to consider the incidents of non-routinised decision making observed on each ward. It concludes by suggesting that the staffing structure plays an important role in determining the types of decisions that get implemented on each ward. As a result of the analysis a distinction emerges between the types of decisions taken by qualified staff and those taken by learners and other unqualified or transient nurses. The emergence of this distinction gave rise to a further literature search on

decision making processes in order to develop a framework for classifying the different types of decisions identified. A discussion of this aspect of the analysis forms the substance of the next chapter.

AN ANALYSIS OF THE ROUTINISATION OF BASIC CARE

The description of basic care given in Chapter Six indicates that, given very limited information about one activity of living, i.e. the level of mobility, the nurses were able to identify and initiate care for patients in three areas of nursing i.e. hygiene, elimination and prevention of pressure sores. This suggests that on these three wards the qualified nurses did not attempt to resolve the dilemmas inherent in nursing practice identified in the Delphi survey. Furthermore they did not give instructions to unqualified nurses as to how these dilemmas should be resolved and individualised care implemented.

Instead, the description of the care given to patients on each of the three wards, in relation to the activities of living incorporated in the observation schedules, highlights the very routinised approach to basic care practised on each of these wards. Moreover, as a researcher it was difficult to identify the dilemmas about the basic care needs of patients articulated in the survey, even though I was highly sensitised to these dilemmas before beginning the observation. If the dilemmas existed at all, the process of resolving them was certainly not made explicit to an

observer.

It is clear from the observational findings presented in Chapter Six that the dilemmas were not resolved by nurses identifying appropriate strategies of care for each individual patient, according to the individual goals of care for that patient. Rather, they were resolved by the imposition of routine solutions which resolved conflicts arising out of the care needs of the patient.

However, further analysis of the routines operating on each of the three wards highlighted differences in the content of the routine, as it was organised on each of the wards. For instance, the post-operative routine for hygiene on the surgical ward was different from the routine for hygiene observed on the medical ward, for patients with a similar dependency level. Both of these routines were different from the hygiene routine observed on the geriatric ward. Differences in routine between the wards were observed for preventing pressure sores, and for giving patients access to toilet facilities. These routines are described for each ward under the appropriate headings in the previous chapter.

Further reflection on the organisation of these routines, for each aspect of care, on each ward, suggested that it was possible to identify aims of care, derived from the survey, which were implicit within the routines used on each ward. This suggested that the routines in use, met the generalised needs of patients in each dependency group on each ward. For

instance, the organisation of hygiene care on the medical ward incorporated the goal of independence by allowing the patient to complete this aspect of care for themselves, only if they failed was help given. Similarly, the mobilisation routine on both the medical and surgical ward supported the aim of promoting mobility post-operatively and following a myocardial infarction. The two to three hourly toileting regime implemented on the geriatric ward, gave rise to regular toileting which could form part of an incontinence control programme.

However, the aim of negotiating care outcomes with patients was rarely observed, even in those areas that the nurses considered to be important on each ward. This suggests that the conflicts inherent in basic care, identified in the Delphi survey, had been resolved by routinised solutions which were applied on each ward to all similar situations. The routinised solutions systematically promoted one set of implicit goals at the expense of other goals. This explains why it was difficult to observe decisions being taken about the dilemmas inherent in care, even though they were acknowledged by the nurses.

As the previous chapter indicated there was evidence, on the acute wards, that the routines were actively supported by the patients. The routines for hygiene and elimination observed on the medical and surgical ward were linked with the mobilisation regime for medium dependency patients.

Gradual mobilisation towards full independence was linked with discharge. Therefore, if the care given to a specific patient deviated from the routine, then the patient might think that they were not making satisfactory progress. This suggestion is supported by the observation on both wards, that patients with a similar diagnoses were observed to confer with each other. Patients nearing discharge would explain the routine to patients newly admitted. Therefore, the patients themselves appeared to recognise that adherence to the routine indicated satisfactory progress. This suggests that even if opportunities were made available to negotiate the aims of care for activities of living, patients may be reluctant to do this, if it meant that the care they were given deviated from the routine with its obvious pointers towards discharge.

This explanation is supported by the work of Roth (1976). Roth identified the importance of routines to patients for identifying progress. According to Roth, certain aspects of care are used as benchmarks by the patients to determine the degree of progress they are making. Roth's analysis indicates that patients may be reluctant to make a choice about their care needs if, in so doing, they undermine a benchmark that may be used by the medical and nursing staff to determine their progress.

The link between hygiene care and mobilisation suggests that if a choice were to be offered to the patient about how their hygiene needs were met, it could involve the nurses in

making decisions that might undermine the recovery of the patient by slowing up their mobilisation, and therefore reducing progress in one of the areas used by nurses, medical staff, and patients, to assess recovery. This suggests that a conflict exists between the aim of offering patients a choice about how their hygiene needs are met, and the aim of preventing the complications of immobility. The routine resolved this dilemma by promoting mobilisation as an aim over that of choice about hygiene needs.

The above analysis suggests that the routinisation of care observed on the acute wards can be partially explained by the fact that it did incorporate aims of care identified in the survey. However, these aims of care were not individualised to meet the needs of specific patients. Instead they were generalised for all patients on the ward who shared a similar level of mobility.

Moreover, the routine incorporated benchmarks used by nurses doctors and patients to assess progress. It was therefore functional in maintaining order on both these wards by establishing the expectations for normal progress. The identification of functional aspects associated with the routine, goes some way towards explaining its persistence on the acute wards. It does not, however, explain the routinisation of care on the geriatric ward, were progression towards discharge was not a predominant theme.

AN ANALYSIS OF THE NURSES' RESPONSES TO THE AIMS OF CARE GIVEN IN THE OBSERVATION SCHEDULES

If we return to the nurses' responses to the aims of care given in the observation schedules, described in Chapter Six, it is apparent that the nurses on the acute wards tended to select aims that reflected those embedded in the routine. In contrast the nurses on the geriatric ward tended to select aims of care that promoted patient autonomy and control. As described in Chapter Six, the nurses recognised that they did not implement these aims in practice, even though they supported them in principle.

This gave rise to a need to examine the routinisation of care observed on the geriatric ward, in order to explain the discrepancies between the routinised care observed, and the individualised aims of care selected by the nurses, and highlighted in the survey. In the light of the above discussion it was also necessary to analyse the care given on the geriatric ward to see if the routines were functional in maintaining order, as suggested on the medical and surgical ward.

The morning routine on the geriatric ward given in the previous chapter offers little opportunity for patient choice, even though as discussed earlier, this was felt to be important by the nurses. If we return to Chapter Four, this indicated that on most shifts there would only be one qualified nurse from the permanent staff on duty. The rest would be learners, agency and bank staff, and the

auxiliaries. There were usually five nurses on an early shift, one floating and one allocated to each of the four patient groups. As it was usually the auxiliary that floated, the qualified nurse had her own nine patients to care for, while the other three groups would be allocated to transient staff.

The qualified nurse, therefore, had to ensure that a minimally acceptable standard of care was given by transient staff who she may not have worked with before. Patients who had been allocated to the care of transient staff who did not know them, if still in bed when given breakfast, might well be in a wet bed, or in urgent need of the commode. Therefore the nurse in charge needed to be able to assess the care given to the other three groups, while at the same time attending to the needs of her own nine patients. If the patients in the other three groups were up and dressed when given breakfast, the nurse in charge could assume that they were at least dry and had used the commode, and therefore a minimally acceptable standard of care had been achieved.

While this method ensured that the nurse in charge could ascertain that this level of care was achieved, it reduced the opportunity for patients to be given a choice about whether or not they were washed and dressed before breakfast. Giving the patients a choice would mean delegating decisions to transient staff whose abilities were not known by the nurse in charge.

It would appear therefore, that the discrepancy between the definitions of nursing produced by the Delphi survey, and the definitions of nursing observed on each of the three wards, can be partially explained by the fact that, on each ward, the routines were functional in maintaining order. On the acute wards they established benchmarks for progress in a situation characterised by both high patient turnover and a high turnover of nursing staff. On the geriatric ward, where the patient population was stable, they enabled the one qualified nurse on duty to monitor the care given by a transient and relatively unknown group of staff, some of whom were not qualified.

The functional explanation of routines goes some way towards accounting for the organisation of basic care observed on all three wards. Moreover, it helps explain how the divergent definitions of nursing, derived from the Delphi survey and from observed practice, respectively, co-exist. This explanation is particularly cogent on the acute wards were the nurses selected, as appropriate, those aims embedded in the routine. As described in the previous chapter, nurses on the geriatric ward accounted for their apparent failure to implement the aims of care they selected as appropriate to the needs of patients, by reference to the rigid organisation of ancillary services. These were felt to be inflexible, and the nurses felt powerless to alter this.

The functional analysis of the persistence of routines fails, however, to explain why qualified nurses were unable

to individualise basic care, but were able to individualise technical care. Neither does it explain the few examples of non-routinised decision making by learner nurses, described in Chapter Six. Finally, the account given above, says nothing about the contribution made to care by learners. Firstly, it is necessary to consider the role of qualified staff in relation to learners, and in particular their ability to individualise technical care, but not basic care, as described in the previous chapter. Secondly, it is important that this analysis also incorporates those situations where learners were observed to give non-routinised care.

DECISION MAKING BY QUALIFIED STAFF

If we return to the literature on the nursing process discussed in Chapter One, it is apparent that it was introduced to overcome the routinised approaches to basic care observed on each ward. However, as described in the previous chapter, whenever qualified staff did attempt to alter the routine for basic care, their attempts were invariably thwarted. They could however, take decisions which substantially influenced the technical care given to patients. Their failure to influence basic care cannot therefore, be explained by a lack of autonomy within the ward environment. In the light of the literature on the nursing process it is possible to argue that the routinisation of care observed on each ward reflected a

failure on the part of the qualified staff to provide unqualified nurses with the information necessary to individualise basic care.

In order to examine this proposition further it is helpful to return to the early morning hygiene routine on the geriatric ward, as on this ward the nurses, both qualified and unqualified, actively supported the idea of promoting patient independence through both rehabilitation, and by giving patients greater control over their own care. However, despite this commitment very little active rehabilitation or patient control was observed in practice for this, or any other aspect of care.

Part of the pressure on the nurses when implementing this care, was derived from the arrival of the breakfast trolley at 8.30 am. It is possible that this pressure could have been reduced, and care given at a more leisurely pace, if breakfasts were served over a longer time period. However, this does not overcome the question of which patient to get up first and which to leave in bed, as most of the patients were either in a wet bed or in urgent need of a commode.

The central problem was not located in providing individualised care for one patient, but in organising the implementation of care by one nurse to meet the individual needs of nine patients. Staggering the serving of breakfast may facilitate rehabilitation and choice for some patients, but may result in the remaining patients being left for a

much longer period of time before any care is given. The problem confronting the nurses was therefore one of prioritising between the competing care needs of nine different patients.

This problem is not resolved by the introduction of care plans which address the needs of individual patients, but do not prioritise between the needs of several patients. As can be seen, given the staffing structure on the ward and the introduction of patient allocation, decisions about the ordering of priorities have been delegated to unqualified learner nurses, or agency and bank staff who are unfamiliar with the needs of each patient.

Moreover as Norman (1987) points out rehabilitation does introduce an element of risk into the care given by nurses. Primarily it contradicts the aim of patient safety. As one student nurse said, she felt she could not allow the patient being observed to wash herself as the patient had been incontinent and the skin might break-down if not properly cleaned. Maintaining safety was seen as very important by the nurses, and was consistently ticked as "necessary" on the observation schedules for medium and high dependency patients. All seven nurses identified it as an aim of care for hygiene on the geriatric ward, as did the six nurses on the surgical ward who completed schedules containing this aim.

Taking risks involves taking decisions about the degree of

freedom and the degree of safety each patient requires. This demands the ability to make informed judgements based on professional knowledge as the care is being given. Uninformed judgements which put the patient at risk could result in the nurse being disciplined or getting a bad ward report. The ability to make informed judgements is dependent on a detailed knowledge of the patients capabilities, knowledge that transient staff, including qualified agency and bank staff, are unable to acquire. Therefore the nurses tended to choose safety at the expense of rehabilitation. Safety, therefore appeared to be a primary goal of nursing care, which took precedence over other aims of care if they contradicted it.

The above analysis appears to suggest that, contrary to most literature on the nursing process, implementing the process is not simply a matter of following a care plan. In reality as Chapter Four demonstrates, on the geriatric ward on her first day, the learner nurse could be confronted with nine heavily dependent patients. All of these patients require care at virtually the same time. The routine on the geriatric ward recognised this heavy demand and attempted to meet it. Individualising care by introducing choice or rehabilitation would require the nurse to prioritise still further between the needs of patients with whom she was unfamiliar. It is apparent therefore, that the introduction of individualised care requires those nurses giving care, be they learners, auxiliaries, bank or agency staff, or

qualified nurses, to take decisions about that care. The need to take these decisions has not, however, been acknowledged in the literature on the nursing process.

The failure of the qualified nurses on the geriatric ward to take the decisions necessary to individualise care, suggested by the persistence of the routine, can actually be seen as a failure of the literature on the nursing process to recognise that individualising care actually requires a delegation of decision making to those nurses who are responsible for implementing it. This goes some way towards explaining the persistence of the routine on the geriatric ward. It is necessary now to consider whether it also applies to the acute wards.

DECISION MAKING BY LEARNER NURSES

On the acute wards much greater emphasis was given to ensuring that each group of patients was allocated to a qualified nurse for the duration of each shift. This process is described in Chapter Four. Therefore, the difficulties experienced in monitoring the care given by learners described on the geriatric ward, was not apparent on the acute wards. However, even despite the higher level of direct supervision achieved on the acute wards, the routinisation of basic care persisted. This can be partly explained by the fact that the routine was more acceptable to the nurses on these wards. Nevertheless the few attempts

made to individualise basic care on these wards, described in the previous chapter, failed. Moreover, some of the incidents in which learners were confronted with the need to take decisions about care, arose on the acute wards. This suggests that the higher level of direct supervision achieved on these wards, did not shield learners from situations in which they were required to take decisions.

As suggested in the previous chapter, it was possible to identify two situations which gave rise to the need for learners to take decisions. The first situation occurred when a discrepancy arose between the care planned, or implied by the routine, and that desired by the patient. The second situation occurred when the care planned, or implied by the routine, was beyond the skill of the learner and no support was available.

Both of these situations suggest that learners could potentially take decisions about care. Moreover, if individualised care was introduced and patients were encouraged to negotiate the aims of care, more patients might request that care is given at a different time or in a different way. However, the literature on the nursing process implies that it is possible to plan care in advance of care giving. This assumes therefore, that patients are able to identify their care needs well in advance of the need for that care to be given.

The difficulties experienced by the researcher, on the acute

wards, in asking the nurses to to make their care plans explicit, described in Chapter Five, highlights some of the difficulties that appear to accompany planning care. On the medical ward the pressure for beds often gave rise to sudden decisions to discharge patients, or otherwise alter the medical plans for patients. Nurses had to respond quickly to these decisions which did not take account of any care planned by the nursing staff. As Pearson (1988) suggests, control over both the admission and discharge of patients is axiomatic to the successful introduction of primary nursing.

On the surgical ward the rapid changes in a patient's dependency level as a result of surgery made it difficult for nurses to negotiate care needs with patients, prior to its actual implementation. As described in Chapter Five, the only realistic way many nurses could complete the observation schedules, was retrospectively. Formulating care plans in advance of care giving, on either of these two wards, was likely to be a fruitless task, as plans could so easily be overtaken by unexpected events.

Moreover, as Chapter Four demonstrated, although learners on the acute wards were rarely allocated to a group of patients without the direct supervision of a qualified nurse, the need to provide supervision meant that very little continuity was achieved in the allocation of nurses to patients. Therefore, very little opportunity existed for nurses, either qualified or unqualified, to become familiar

with the needs of a small group of patients. Instead, in order to provide adequate supervision, qualified staff had to be aware of the needs of every patient on the ward.

Under these circumstances, even if a staff nurse did become familiar with the needs of her group of patients, she could find that the care plans she had formulated were overtaken by unanticipated events; be they decisions by medical staff, or changes in the way the patient felt about their care. This could occur even when she was on duty, but allocated to a different group of patients in order to provide adequate supervision of the learners attached to that group.

The incentive to develop care plans which are changed in her absence and which are likely to become increasingly irrelevant to the patient's changing situation, is therefore minimal. Moreover, the difficulty in planning care in advance of care giving, because the patient's needs change rapidly, indicates that the introduction of individualised care could more effectively be achieved if those nurses giving care, took decisions about the content of that care as they were implementing it. It would appear that like the geriatric ward, individualising care on the acute wards, involves delegating decision making to those nurses who actually implement it e.g. a transient workforce of learners, agency and bank staff, who have little or no knowledge about the patients. Similarly it would also involve delegating decision making to auxiliaries who are not yet trained in the principles of individualised care.

The difficulties identified in planning care in advance of implementation can be contrasted with the failure of qualified staff to give instructions about the basic care needs of patients, to learners. Clearly on all three wards learners, auxiliaries and bank and agency staff, have the potential to substantially alter the care given to patients. Indeed, on one occasion an agency nurse was observed to do just that. The fact that on most occasions these nurses do not take decisions which substantially change the care given to patients, suggests that these nurses chose to implement the ward routine. The suggestion that individualising care involves delegating decisions to learners, appears therefore, to account for the routinisation of care observed on all three wards. It suggests that learners maintain the routine by failing to take the decisions necessary to individualise care, or to prioritise between the care needs of different patients.

Moreover, it also suggests that learners do take decisions, they take the decision to adhere to the routine. A decision the qualified nurses appear unable to alter. This suggests that definitions of decision making contained in the literature on the nursing process are inadequate in explaining the full range of decisions taken by nurses in relation to care giving. The next chapter considers the literature on decision making in large organisations, and uses this literature to classify the types of decisions

taken by different grades of nurses.

CONCLUSION

This chapter addressed the primary aim of the research which was to identify the contribution learner nurses make to the care of patients. It utilized the principles of analytical induction which provided a framework for this analysis.

It began by considering the routinisation of basic nursing care observed on each ward. It found that the routine was functional in maintaining order on each of the three wards. This finding did not, however, explain the non-routinised approach to technical care observed on the wards, neither did it explain the incidents non-routinised basic care described in Chapter Six.

At this point the findings of Chapter Four, which described the staffing structure observed on each ward, were introduced to the analysis. This indicated that individualising basic care on the geriatric ward would result in a delegation of decision making to learners and other transient staff who were responsible for implementing the care of patients, but who were unfamiliar with the needs of each patient. This proposition was tested on the acute wards which were characterised by a very different patient population and staffing structure. Here difficulties were identified in individualising care in advance of care giving either because patients' dependency levels changed rapidly and their desires following these changes could not be

anticipated, or because decisions were taken by medical staff which required prompt action, but which rarely took account of nursing care plans. Moreover, despite the higher levels of supervision achieved on the acute wards, the need to supervise learners undermined continuity in the allocation of nurses to patients, so again the nurses giving care were unfamiliar with the specific needs of individual patients.

This chapter concluded by suggesting that on all three wards the introduction of individualised basic nursing care required a delegation of decision making to learner nurses, and other transient staff, who unlike the qualified staff, were in a position to substantially change the basic care given to patients. This finding highlighted the need to consider the assumptions about decision making inherent in nursing practice literature. In order to address these assumptions a further literature search was undertaken which identified models of decision making found in large organisations. These models are described in the next chapter and used to develop the analysis of the contribution made to care by learner nurses.

Chapter Eight

Decision Making and Accountability In Nursing Practice

Introduction

This chapter considers the analysis of nursing care given in Chapter Seven, in relation to a wider literature on decision making processes in large organisations. It uses this literature to classify the types of decisions taken by the different grades of nurses, and produces a critique of the assumptions about decision making inherent in the nursing process literature.

The analysis of decision making processes in nursing gives rise to a consideration of the concept of professional accountability in nursing practice. The second part of this chapter addresses this issue. It develops the analysis of the findings of this research by examining the problems confronting nurses who wish to develop professional accountability in situations where they are dependent on an unqualified and/or transient workforce.

THE NATURE OF DECISION MAKING IN NURSING PRACTICE

The separation of decision making, i.e. care planning, from implementation, which seems to characterise most texts on the nursing process, appears to conform to a rationalist model of decision making. Hunter (1980) identifies three stages which characterises the rational model of decision making.

1.The decision maker considers all of the alternatives (courses of action) open to him.
2.He identifies and evaluates all of the consequences which would flow from the adoption of each alternative.
3.He selects that alternative the probable consequences of which would be preferable in terms of his most valued end.

(Hunter 1980 p.47)

As Hunter points out, the rational model of of decision making is underpinned by a number of assumptions. For instance the model suggests that there is widespread agreement about goals and objectives, and all personnel are engaged in identifying the best possible strategy for achieving the agreed goals. This means that all possible strategies are reviewed, and the undesirable consequences of each strategy identified, so that the best possible course of action can be selected.

The introduction of the nursing process can be seen to reflect the classical model of rational decision making, described above. The nursing process literature suggests that the qualified nurse undertakes an assessment designed to identify the care needs of each patient. The nurse then formulates goals of care and reviews the alternative nursing strategies available to achieve the goals of care. The nurse then selects the most appropriate strategy for achieving the desired goals of care for the patient, and this is entered in the care plan. Care is implemented according to the plan, and its effect on goal achievement evaluated. If the goals of care are not met the planning cycle begins again. The introduction of the nursing process can be seen therefore as

the most recent application of scientific management techniques to nursing. As Hunter points out much of the work of the school of scientific management is orientated towards developing techniques which "bring decision-making more in line with the rational model" (Hunter 1980 p.47).

However, many of the assumptions which underlie the rational model have been questioned, and in Hunter's term "discredited" by alternative developments in organisational theory, and it is to these developments that we must turn to explain the failure of the nursing process and bureaucratic methods of work organisation to control the nursing agenda for basic care, and so determine what happens to patients.

Much of the criticism of of the rational model can be traced back to the work of Simon (1954). Simon developed the theory of bounded rationality. This theory suggests that real constraints operate to reduce the extent to which rationality as a goal can be achieved in any organisation. He suggested that all organisations are characterised by conflicts and ambiguities in the identification of goals and objectives. Therefore, the assumption of agreed goals, underpinning the rational model could never be openly realised. He also highlighted the difficulties inherent in accurately identifying the desirable and undesirable consequences of alternative courses of action designed to meet organisational goals. Here, he was suggesting that the consequences of implementing potential strategies were by no means obvious to the planner.

The theme of bounded rationality developed by Simon was taken up more recently by Sharkansky (1972). Sharkansky was concerned to identify the processes by which strategies came to be selected for implementation from the vast number of potential strategies. He identified that the selection of strategies was dependent on the use of decision rules. Decision rules can be seen to provide a framework within organisations which is used by decision makers to take decisions.

One of the main decision rules identified by Sharkansky was the use of routines to govern decision making. Routines, he suggests, are used as a method of simplifying the complex considerations that are potentially relevant to a decision maker. Routines are defined as the "decision rules that specify which of the numerous inputs that might be relevant are actually considered in making decisions ... they enable the decision maker to select ... those few considerations to be kept in mind from among the myriad that are potentially relevant" (Sharkansky 1972 p.61).

The use of decision rules described, by Sharkansky, which operate through routines to guide decision making, have been analysed by Bachrach and Baratz (1972). In their analysis, Bachrach and Baratz introduce a political dimension to decision making, which they identify as operating through the concept of the non-decision. Bachrach and Baratz demonstrate how decision rules operating through routines

give rise to a "mobilisation of bias", which in turn gives legitimacy to the non-decisions. Mobilisation of bias is defined as "a set of predominant values, beliefs, rituals, institutional procedures ('rules of the game') that operate systematically and consistently to the benefit of certain persons and groups at the expense of others" (Bachrach and Baratz 1972 p.43). As a result of their analysis, they indicate that certain issues or grievances which emanate from the less powerful members of the group, are effectively blocked from becoming full-fledged issues which call for decisions. When this arises, it can be said that a non-decision making situation exists.

For the purposes of this research, the contribution of Bachrach and Baratz lies in their identification of the mobilisation of bias evoked by the routine, which identifies those issues that enter the agenda and give rise to a decision, and those issues that remain outside the framework of the routine, and therefore do not enter the decision making arena.

Parry and Morriss (1974), in a critique of Bachrach and Baratz, argue that by introducing a political dimension Bachrach and Baratz imply that those in power in any system consciously mobilise the bias inherent in the routine to the detriment of less powerful participants. In their critique, they argue that Bachrach and Baratz fail to distinguish between three different forms of power associated with

routines. Parry and Morriss distinguish between:-

1.The people in power and the situations that gave rise to the initial routine and its inherent bias.
2.The officials who inherited the routine and take decisions according to the framework of the routine without being aware of the bias they are in fact perpetuating.
3.The distribution of power which is consequential on the performance of the routine.

(Parry and Morriss 1974 p.332).

Parry and Morriss argue that Bachrach and Baratz confuse these three types of power, consequently their analysis cannot accommodate the mobilisation of bias by those who inherited the routine. As Parry and Morriss point out, this restricts the identification of non-decision making to those situations in which it could be observed that the bias was consciously mobilised to the detriment of certain less powerful groups of people. By differentiating between three different forms of power inherent in the routine, Parry and Morriss argue it is possible to identify restrictions on the parameters of decision making arising from the mobilisation of bias by those who have inherited the routine. The implications, they suggest, of decisions emanating from the routine may not, in fact, be supported by those seen to perpetuate the routine.

As a result of their analysis, Parry and Morriss reject the term non-decision in favour of the terms decisionless decision, or routine decision. They argue that non-decisions must, in fact, be defined as decisions, but not the key decisions analysed in pluralist or rationalist decision making theory, described above. Instead, they reflect the

lesser decisions described by Simon (1954), Sharkansky (1972), and Bachrach and Baratz (1972).

The above analysis of theories of decision making highlights the limitations of the rationalist model of decision making. It suggests the existence of decision rules which utilise routines to identify the major considerations in any decision making situation. Ambiguities and contradictions are resolved by reference to the routine, which incorporates a bias which supports the orientation of those people who initiated the routine, but which may now be obsolete. However, those who inherit the routine will continue to use it as their major frame of reference, as new routines to facilitate decision making have yet to evolve.

This, in fact, would appear to be the process that was operating on each of the three wards. The introduction of aims of care which reflected the social or wellness model of health, were sometimes recognised by the nurses. However, they were still operating in a system which conflicted with these aims at crucial points. The routines that the nurses used to govern decision making reflected the medical model, which defined basic nursing care as unskilled. Although the nurses recognised that it was not unskilled, they had not, as yet, developed alternative routines to govern decision making which identified the decision making components involved in individualising basic care.

If we return to the literature on the nursing process, it is

clear that it evolves from rationalist theories of decision making which assume a consensus exists over the goals of care and strategies designed to bring about those goals. The literature fails, therefore, to identify the potential conflicts in patient goals, and difficulties in identifying appropriate nursing care strategies in order to provide patients with an individualised programme of basic care. Nurses implementing the nursing process are left to confront inherent contradictions without guidance from those who introduced the process, and who suggest that the failure to provide individual care is a consequence of inadequacy on the part of the ward sister (Pembrey 1980, Ogier 1982), and not an inherent problem with the process itself.

Instead, the findings of this research highlight a number of dilemmas which confront nurses attempting to individualise care. At a micro level, the nurse implementing care has to prioritise the care planned in the care plan, and resolve any ambiguities that may exist in the plan i.e. between the goals of the organisation which on the geriatric ward involved re-housing the patient, and the goals of the patient, which in many cases were to go home. On the medical and gynaecology ward, individualising basic care involved undermining benchmarks which were used by patients, medical staff, and nurses to monitor progress towards discharge. Similarly, on the geriatric ward the nurse in charge had to delegate care to a relatively unknown workforce, who possessed only minimal knowledge about the patients, while

at the same time she had to implement care for her own group of patients. At a structural level it would appear that ward dependence on a learner nurse workforce meets educational and manpower demands within the service, but acts as a constraint on the introduction of individualised care.

The distinction made in the literature between key decisions and routine decisions appeared particularly helpful in understanding the organisation of decision making on each of the three research wards. It indicated that the literature on the nursing process recognised only the key decisions identified by Parry and Morriss (1974), but failed to acknowledge the effects of routine decisions on the organisation of care. While this distinction explains the routinised approach to care adopted by the learners, it does not explain why the qualified staff were able to individualise technical care, or why they accepted the use of the routine as a framework for the care given by learners.

As discussed earlier, the non-routinised decisions observed to be made by learners, arose from dilemmas which they were confronted with when implementing care. Most of those dilemmas were initiated by the patients refusing to adhere to the care routine. Some were initiated by the learners lacking the skills necessary to implement the instructions given by the qualified staff. However, as Chapter Six demonstrates, the basic care given by learners primarily adhered to a ward routine. For the most part this routine

operated at the lowest common denominator of care. This reflects the short time that transient nurses have to assimilate the care needs of up to 14 strange patients, and the fact that the skill level of the nurses giving care was unpredictable. Sporadic improvements in care were found to be disruptive and difficult to sustain. It is suggested, therefore, that most nursing care actions undertaken by learners result from a routine decision and that predominantly learners choose to implement the ward routine.

Basic care can be seen, therefore, as the province of learners, auxiliaries, and transient staff, and it is these nurses and not the qualified staff who influence the organisation of care at this level. These learners, auxiliaries, and transient staff, however, are not responsible for implementing therapeutic care derived from medical and technological interventions. This remains the province of the qualified staff who are in a position to individualise this type of care, and who were in fact, frequently observed to do so. The suggestion, therefore, that the routinisation of basic care reflects a failure on the part of qualified staff to take the decisions necessary to individualise care, is misleading, because it assumes that qualified staff control the nursing care agenda at this level. As the discussion of decision making suggests, while qualified staff may take key decisions that individualise basic care these decisions can be re-interpreted by those responsible for implementing this care. The process of re-

interpretation utilizes the routine which serves to undermine the key decisions taken by the qualified staff.

This analysis suggests therefore, that the nursing care routine is used by those implementing care to resolve dilemmas in the care planned. Consequently it is the nurses who implement care and not those who plan it, who control the agenda about basic care in hospitals and determine how these needs are met.

The concept of individualised care, discussed in Chapter One, implies that patients with a similar diagnoses or who share a similar dependency category, could have very different nursing care needs. These needs reflect their differing life circumstances and understanding about their illness, as well as their differing expectations and goals. Meeting the individualised care needs of patients implies developing innovative approaches to care. The more innovative the care, the more likely it is to differ from that given on other wards in the hospital, or even other patients on the same ward. This process is illustrated in the following case study. One of the sisters had introduced an innovative approach to assessment of patients on admission, but experienced difficulties in getting the nurses to regularly use this assessment.

> The sister on the gynaecology ward had developed a much more systematic approach to the assessment of patients on admission than was used on other wards in the hospital. This was developed in preparation for the introduction of the nursing process. She

frequently complained that the nurses did not use this assessment when admitting patients. On one occasion she was observed to complain to the staff nurse that an agency nurse she had taught the previous month to use the assessment, had failed to do so when she admitted a patient that morning. When questioned by the sister, the agency nurse said she had completely forgotten that a different approach to assessment was taken on this ward. It transpired that she had worked on a number of different wards in the intervening period and had continued to use the assessment methods found throughout the rest of the hospital.

This suggests that if the care differs too much from ward to ward or patient to patient, then the extent to which transient staff can be fully employed on a ward without intensive re-orientation is substantially reduced. As the analysis of the staffing structures on these wards given in Chapter Four indicates, opportunities for re-orientation are limited given the high throughput of transient staff, and the substantial contribution they currently make to patient care. The quick and effective utilisation of transient staff requires those staff to be able to recognise quickly, and with minimum instruction, the care needs of patients on the ward. This is greatly facilitated if the care given on a ward is similar to care given on other wards in the hospital i.e. if it conforms to a routine. Moreover the sisters appeared to accept the use of routines to determine nursing work, as they are dependent on a transient workforce to implement much of the care given on the ward.

The implication that the agenda for basic nursing care is controlled, not by the qualified staff, but by the transient and unqualified nurses responsible for its implementation,

contradicts most of the assumptions about authority within hierarchical organisational structures. An understanding, therefore, of this implication requires an examination of the nature of authority and accountability within bureaucratic and professional types of work organisation.

ACCOUNTABILITY IN NURSING

Accountability is frequently regarded as the hallmark of professional practice, as it acknowledges the practitioners' relative autonomy from the authority of the organisation in which they operate (Burns and Stalker 1961). Most literature places accountability for the care given to patients with the qualified nurse in charge of the group of patients (McFarlane and Castledine 1982), or the ward sister or charge nurse (RCN 1980), while at the same time suggesting that care can be implemented by unqualified staff.

A useful operational definition of accountability in nursing is given by Batey and Lewis (1982). They define accountability as "the authority to take decisions within a defined sphere of responsibility". In their discussion of accountability, they suggest that professional accountability is derived from the authority of expert knowledge. The authority of expert knowledge suggests that an individual exercises authority as a result of the personal attributes (skills and expertise) which they possess, and which are a pre-requisite for being given a post. It promotes a professional orientation in that it is

dependent on the skill of the person rather than the post they hold. Therefore, this authority cannot be delegated as it is derived from the individual and not the post. However, Batey and Lewis argue, while the authority of the expert cannot be delegated, they can delegate the charges or responsibilities emanating from the post. However, if they delegate certain aspects of the job, it is they, and not the person to whom the actions are delegated, who retain accountability for the consequences of delegated actions.

Batey and Lewis's discussion of professional accountability turns, therefore, on the authority to take decisions. If there is no authority to take decisions about the content of nursing work, then, according to Batey and Lewis, there can be no accountability. A person can only be held accountable if they take a decision about work content, and then only for the consequences of the aspect of work about which they took a decision.

Patient Allocation and the Practice of Accountability

As discussed earlier the nursing process and systems of patient allocation were designed to promote individualised care in nursing. The qualified nurse in charge of the team is responsible for developing an individualised care plan which can be delegated to unqualified staff for implementation. According to the definition of accountability developed by Batey and Lewis, providing the unqualified staff adhere to the care plan, they are not accountable for the consequences of its implementation. This

explains why on each ward it was felt important that a qualified nurse with sufficient knowledge about all the patients was available to authorise any changes in the care plan which may be required.

In their discussion on professional accountability, Batey and Lewis point out that if a nurse is to be held accountable for care given to patients, three conditions need to be satisfied:-

1) A nurse can only be held accountable for those areas in which she exercises autonomy, ie. takes decisions about the care.

2) A nurse can only be held accountable if she is able to act on the decisions she has taken.

3) A nurse can only be held accountable if she is able to exercise control over the resources necessary to implement the decisions she has taken.

(Batey and Lewis 1982)

These conditions suggest that if the ward sister is to be held accountable for care given on her ward, at a minimum she must be able to choose the nurses working on the ward and be sure that they have the necessary expertise to implement care planned to the desired standard. Similarly, if the team leader is to be held accountable for nursing given to patients by her team, she would need a comparable level of control. Moreover, if authority to take decisions about care in the absence of the team leader is to be devolved to members of the team, then the Sister and team leader must be satisfied that the nurses to whom this has

been devolved will take decisions in line with the overall policies of the ward.

It is possible for the sister to be consulted about the appointment of staff and enrolled nurses attached permanently to her ward, and for the team leader to be similarly consulted about the nurses attached permanently to her team. Under these circumstances both the Sister and the team leader can delegate both the implementation of care and some decision making to the nurses working under them, as they will exercise some control over who these nurses are and will have some opportunity to identify the nurse's level of competence. As Batey and Lewis point out, the exercise of control over resources such as these is fundamental to the exercise of accountability.

The sister and team leader do not, however, exercise any control over learners, agency nurses, or bank nurses allocated to the ward or team and as Appendix M illustrates, these nurses provided by far the greatest proportion of staff found on each ward. Given this high proportion of transient staff it is questionable whether sisters or team leaders can retain accountability for care, if decision making about care is delegated to transient staff.

They could, however, retain accountability if transient staff only took responsibility for implementing planned care. However, as the previous discussion of decision making, suggests, this does not necessarily promote

individualised care. On each ward the nurses were able to identify different aims of care to those being practised on the ward. They found it difficult, however, to identify how these aims could be implemented in practice. The introduction of individualised care, such as giving patients a choice about hygiene needs, mealtimes, or developing individualised mobilisation regimes or incontinence control programmes, appeared to require the nurses giving care to be aware of the individual priorities for care identified for each patient. This gives rise to two problems. Firstly, it means that transient staff need to learn quickly the individual priorities of a large group of patients. Secondly, it entails an element of risk, such as when mobilising a patient, or allowing a patient to feed themselves, which may mean that they get only a minimal diet. This implies that the nurse giving care is aware of the priorities for care for the patient in question, and possesses the skills necessary to take the calculated risks involved.

It would appear that accountability, as defined by Batey and Lewis (1982), like the literature on the nursing process, recognises only the key decisions of rationalist theories of decision making. They too fail to acknowledge the routine decisions involved in implementing instructions. Instead, they suggest that tasks can be delegated while decision making, and therefore accountability, is retained. This again fails to recognise the judgement required to transform

a decision into a nursing care action, which, as Schon (1983) points out, is the hallmark of reflective professional practice.

As suggested above, the separation of decision making from the implementation of care, implied by the theory of accountability proposed by Batey and Lewis (1982), and supported in the literature on the nursing process, is, in fact, questionable. Instead, the analysis given in this chapter indicates that the qualified staff have to accept the constraints on care imposed both by the level of skill of the nurses allocated to work on the ward, and the level of paramedical facilities available at the hospital. The analysis also suggests that, in order to implement individualised care, the nurse in charge would have to be sure that the nurses giving this care understood the priorities for care identified for the patient, and were competent to implement them at an agreed level. Clearly, the rate of nurse turnover experienced on these wards means that, for the most part, the qualified nurses are unable to ascertain the skill level of the nurses assigned to care for the patients. If individualised care programmes were introduced, some transient nurses, such as agency staff, would have to become cognizant with up to 14 different care plans (in the case of the medical ward) for the duration of one shift. At the same time the qualified nurses would have to accept that decisions that involved calculating the risk to the patient of a given care regime would be delegated to

transient nurses whose level of skill is not known by the permanent staff.

If, as this research suggest, decision making is an inherent component of all nursing care actions, then the theory of accountability proposed by Batey and Lewis (1982) implies that it is the transient nurses and not the permanent nurses who are accountable for care. However, as the permanent staff have no prior knowledge of the skill levels of the transient staff and are not involved in their selection to work on the ward, this theory also implies that the permanent staff cannot be held accountable for the consequences of decisions taken by these nurses.

It would appear that rather than devolve accountability to transient nurses, the sisters on each of these wards had chosen to adhere to the method of nurse management proposed by Bailey and Claus (1975). Bailey and Claus recognise that nurse managers cannot personally perform all the duties necessary to implement decisions; some tasks must be delegated to subordinates together with the authority needed to carry out the task. They also suggest that all routine and recurring jobs or tasks should be delegated. They propose that once a decision as to what nursing care should be given has been taken, qualified nurses should develop procedures which specify how each particular aspect of nursing care should be performed. The procedures are guides for action which Bailey and Claus maintain are useful for repetitive tasks. Procedures, they argue, enable the worker

to focus on accuracy and speed and promote consistency and uniformity in the quality of work.

This suggests that the model of accountability currently in operation on each of the wards, reflected the model produced by Batey and Lewis (1982). Given this model, accountability for patient care rests not with the nurses giving care, but with the sister or qualified nurse who plans the care. However, in order to adhere to this method of accountability, the sister had to accept that the agency, bank, and learner nurses giving care would adhere to a ward routine when ordering priorities, a routine that is known to, and agreed by, the sister or charge nurse. By establishing a routine which is similar in form to the routines used on other wards, but which also promotes the priorities for care required by the majority of patients on the ward, the sister or charge nurse can retain accountability for the care given by transient staff providing they follow this routine.

Similarly, transient nurses working in an unfamiliar environment are absolved from accountability for the care they give if it conforms to the routine sanctioned by the sister or charge nurse. Failure to establish a routine which identifies the priorities for care, and standards at which it is implemented, implies that the degree of control over the standard at which care was given would be devolved to transient and unqualified nurses.

As illustrated in Chapter Six, attempts by qualified staff to individualise basic care were by and large unsuccessful. In one instance, it was the staff nurse herself that implemented the routine in direct contradiction to the instructions about this patient's care, that she had given earlier. Clearly, the staff nurses accept that care that is predominantly implemented by transient staff will conform to a routine, and that any attempts they make to alter this are likely to be sporadic and inconsistent. Moreover, as the staff nurse who tried to implement passive exercises on an elderly patient discovered, embarking on individualised care that cannot be sustained, can simply serve to disrupt the normal routine for the patient, whilst not providing any tangible benefit.

The analysis given in this chapter suggests that wards which depend on learners to implement much of the care given to patients cannot introduce individualised care regimes for patients, as to do so involves delegating decisions about care to nurses whose level of skill is unknown to the sister. This would undermine the degree of accountability the sisters could exercise over the care given to patients. Conversely, the analysis suggests that transient staff do take decisions. They are not, however, key decisions, but instead reflect the description of routine decisions given by Parry and Morriss (1974). This involves the use of the ward routine to resolve the dilemmas embedded in practice. Faced with this situation, it is suggested that

sisters/charge nurses tacitly accept that it is the transient staff giving care who set the nursing care agenda on the ward, and not the qualified staff who plan the care. Routines therefore become the medium used by sisters and charge nurses to control standards of care in the face of a fluctuating and largely unqualified workforce.

CONCLUSION

The analysis of care described in this chapter explains the contribution made by learners in terms of their control over the decision making process for basic care. It suggests that learners choose to implement this care in a routinised manner as they frequently lack the skill or knowledge about the patient which is necessary to individualise care. Moreover, adhering to the routine absolves them from being held accountable for the care they give. It is suggested that qualified nurses sanction the use of the routine as they are dependent on learners to implement basic care. Moreover, the routine encompasses aims of care that meet the predominant needs of most of the patients in a given group. In this way it enables qualified staff, who set the routine, to retain accountability for important aspects of care on each ward.

The above analysis was arrived at through the method of analytical induction as described in Chapter Two. Explanations which did not apply to all three wards were rejected in favour of an analysis that explained the

contribution learners made to care across all three wards. This analysis took account of the analytical categories derived from the observational data and presented in Chapter Six, indeed it was organised around the classification of data given in that chapter. It also incorporates the divergent definitions of nursing produced from the Delphi survey and from the actual observations of care, and explains how these definitions were accommodated by the nurses on the observation wards. Finally it reinforces the analysis of the staffing structure given in Chapter Four and indicates that the structure plays a major role in sustaining the routinisation of care observed on each ward.

The next and final chapter provides a summary of the findings of this research which focuses on the specific contribution learner nurses make to maintaining routinised approaches to nursing. It discusses this contribution in the light of earlier research on the routinisation of nursing care. Finally, the next chapter goes on to evaluate the methods used in this research and to consider the implications of both the methods used and the findings presented, for further research.

Chapter Nine

Discussion And Conclusion

Introduction

This final chapter discusses the findings of the research in relation to nursing practice and manpower planning. It highlights the contribution this research makes to the development of our understanding of the routinisation of basic nursing care. It also reviews the strengths and limitations of the methodology developed in this research and finally it discusses areas which require further research in the light of these findings.

IMPLICATIONS FOR NURSING PRACTICE AND MANPOWER PLANNING

This research focuses on the effects on the nursing service of dependence on a learner nurse workforce. It has found that the secondment of learners to wards as part of the staffing establishment of those wards, gives rise to a transient and unstable staffing structure. For instance, the medical and gynaecology wards averaged a new nurse once a fortnight, while the geriatric ward received a new nurse, on average, every week. This problem was compounded by the use of agency and bank nurses to compensate for an under-allocation of learners. Under-allocation occurred between 38% and 65% of the time on these wards. Therefore one ward was dependent on agency and bank staff for over 50% of the time. Changes in the training syllabus, which reduce the allocation of learners to wards, can, therefore, be seen to

have identifiable consequences for the structure of staffing at ward level.

The well documented high turnover rate in nursing described in Project 2000 (UKCC 1986) gives rise to large numbers of learners passing through nurse training wards. Given this high dependence on learners as part of the workforce, it is difficult to apprentice them to a qualified nurse. As this research indicates, the total number of nurses available on wards is insufficient to allow qualified staff and learners to be given similar off-duty. Tables Thirteen and Fourteen in Chapter Four indicate that the qualified nurses are frequently running the ward whilst the learners, on the other hand are primarily responsible for implementing care. Given these two very different roles the opportunities for the direct supervision of learners by qualified staff is limited.

The introduction of systems of patient allocation serves only to complicate the problem still further. As McFarlane and Castledine (1982) suggest, in order to provide continuous cover to the same group of patients, learners, who work as part of a team of nurses, should work opposite the qualified nurse heading the team. It is difficult, therefore, to see how direct supervision of learners can be arranged, as the qualified nurses on duty with the learner will be caring for other groups of patients. There appears, therefore, to be a conflict of interests between providing

adequate and continuous supervision of a learner from a named qualified nurse, which implies that they work together, and providing continuous care to patients from the same group of nurses, which implies that learners and qualified staff caring for the same patients work opposite each other. This was found to be a dilemma on each of the three wards observed during this research. On both the gynaecology and medical ward, it was resolved in favour of the supervision of learners. However, this solution gave rise to considerable discontinuity in the allocation of nurses to patients, as Appendix K demonstrates.

On the geriatric ward, the introduction of patient allocation created an even greater problem, as it was only possible to allocate one nurse to a group of patients at any one time. Therefore the qualified nurse had to run the ward, implement the care required by a group of nine highly dependent patients, and supervise the care given by unqualified or transient staff to up to three other groups of heavily dependent patients. Frequently, the only qualified nurse on duty was an enrolled nurse. The data collected in this research indicate that the introduction of systems of patient allocation means that learners are subject to a variety of supervisory arrangements. On the gynaecology and medical ward, direct supervision was frequently given by Enrolled nurses, and bank and agency staff, as these nurses tend not to run the ward, but instead are allocated jointly with learners to provide care for a

specified group of patients. On the geriatric ward they were indirectly supervised by a qualified nurse caring for a different group of patients.

The results of this research indicate, therefore, that the staffing structure of nurse training wards is characterised by dependence on learner nurse labour. This gives rise to an unstable structure in which the proportion of transient nurses far outweighs the permanent staff.

The Effects of Ward Staffing Structures on Individualised Care

The difficulties in introducing continuity in care, demonstrated in this research, were found to undermine the introduction of individualised care. The research findings suggest that the introduction of individualised care requires continuity in staffing, so that the nurse can become acquainted with the patient as a person, and develop an understanding of the patient's history and aspirations. It is suggested that it is only under these circumstances that nursing can incorporate mutually agreed and negotiated goals of care. The high levels of transience which characterised these three wards meant that the routine care given to patients reflected only minimal knowledge by the nurse of the care needs of patients. Even when a greater level of knowledge was available and known by the nurse, it was rarely used in the context of basic care, as it could not be assimilated by transient nurses prior to care giving, and therefore, could not be used on a regular basis. There

was some evidence to suggest that the sporadic use of knowledge about the patient, to inform care was ineffective, as the effort was not maintained, and could be disruptive for the patient, and in turn the staff. It served, therefore, only to raise issues that could not be resolved or expectations that could not be met.

It is suggested, therefore, that even if nurses plan individualised care through the nursing process, in practice it will be difficult to implement, as the agenda for basic care is set, not by the individual needs of patient, but by the ward routine. This is sanctioned by the qualified staff, as it provides a quick and efficient means of utilising transient staff, while at the same time maintaining control over the standards at which care is implemented. This point has been made in a recent article based on this research (Procter 1989).

This highlights the ambiguity which currently surrounds the role of the learner nurse in relation to decision making. The introduction of the nursing process reflects rationalist theories of decision making, which focus on key decisions. It fails, therefore, to recognise that every action is the result of a decision. Unqualified staff cannot be shielded from the process of decision making, as suggested in the literature. Instead, they do take decisions, these decisions do not, however, conform to the rational model, rather, they reflect the process of routine decision making described by Parry and Morriss (1974). As this research demonstrates

learners, during the course of their work, do take decisions, they make decisions about care priorities, not only to one patient, but also between patients. They assess the risk to patients of therapeutic regimes such as mobilisation, and also take decisions about their own level of skill in giving this care. They respond to the demands of patients, even if these demands differ from the care specified by the qualified staff. In taking these decisions, unqualified staff could substantially alter the care given to patients, and even determine the standards of care found on a ward.

However, because they adhered to the process of routine decision making the potential of unqualified staff to determine the care needs of patients was rarely observed. Instead, the care they gave reflected the ward routine. It is suggested that in choosing to implement the routine, they reduced the extent to which they could be held accountable for the consequences of the care they gave, as the routine was known to and sanctioned by the qualified staff, who would therefore be accountable for the consequences.

This research indicates that given the large numbers of transient and unqualified staff, and the substantial contribution they currently make to care, the routine will tend to dominate those aspects of care that are regularly delegated to them. Under these circumstances it is difficult for permanent qualified staff to impose their own

definitions of care onto a volatile workforce. They can only develop their own definitions of care by reducing their utilisation of transient and unqualified staff. Moreover, it explains why the non-routinised decisions taken by the qualified staff tended to be in the area of technical care rather than basic care, as the area of technical care is the province of qualified staff, and therefore they have more control over the agenda at this level.

Professionalisation in the Context of Transience

The recognition that learners and other unqualified staff do take routine decisions when implementing care has consequences, both for professionalisation and for accountability.

As discussed in the first chapter, professionalisation is premised on expertise. Without expert knowledge which provides a desired service, there can be no basis for the development of a profession. Schon (1983), in his discussion of professional knowledge, differentiates between knowledge derived from technical research and knowledge derived from experience. Expert professional practice, he suggests, requires the ability to adapt technical knowledge to the specific, messy and frequently unique combination of factors presented by an individual client to the practitioner. His description of this process is similar to that given by Benner (1984). She differentiates between the novice and the expert in nursing practice. Expertise, she suggests,

develops when the practitioner tests and refines technical or principle based knowledge in actual practice situations. She suggests that the behaviour of the novice is necessarily governed by rules or procedures of practice which are inflexible. This allows them to gain entry into the practice situation in order to acquire the experience necessary to develop expertise. However, initially the rule bound behaviour will mitigate against successful performance, because it does not allow them to identify the most relevant tasks to perform in practice.

The analysis of the development of expertise given by Benner (1984) and Schon (1983) suggests, that at an initial level, practitioners, whether qualified or unqualified, use rote learning or mechanistic routinised approaches to care. It is only as a result of reflection on practice, which synthesises technical knowledge with experience, that expertise develops. Clearly, the concept of a workforce comprised solely of experts is unrealistic, some hierarchy of skill acquisition must exist on every ward. This raises the question of how to avoid routinised approaches to care in the face of inexperienced practitioners, whatever their initial qualifications. Again the proportion of novices to experts may make a difference.

Interestingly, Benner suggests that the development of expertise fits a situational rather than trait model. By this she means that an expert in one area or department will become a novice if transferred to an unfamiliar clinical

setting, since she has no experience of the patient population or knowledge about the goals or tools of patient care. This is certainly reinforced in this research, where qualified agency and bank nurses were found to organise the implementation of care using the same routines as learner nurses. Despite being qualified and perhaps extremely experienced as nurses, their lack of familiarity with the clinical environment prevented them using their expertise, and instead their practice resembled that of a novice.

It appears, therefore, that these wards were dependent on transient nurses, who were novices either because they were learners, and/or because they were working in an unfamiliar environment. These nurses were used primarily to implement the basic care required by patients, consequently the organisation of this care could never go beyond that which could be performed by a novice. In other words, it would be mechanistic, rule bound, procedural and inflexible. The introduction of supernumerary status following the implementation of Project 2000 (UKCC 1986), may go some way towards reducing dependence on a transient workforce. However, the problem will remain if manpower systems which allocate a reserve workforce of nurses to wards for half shifts to cover measured fluctuations in workload, persist. These findings suggest that manpower planners need to rethink the issues surrounding fluctuating, workloads and to recognise the importance of promoting continuity of care within the basic design of the systems in use. They also

highlight the gross inefficiency that results from manpower systems which reduce the operational level of an experienced nurse to that of a novice.

Accountability in the Context of Transience

The above discussion implies that initially all nurses new to an environment will give routinised care. This will persist until such time as they have acquired sufficient experience to develop more flexible approaches with confidence. The problem confronting nursing, therefore, is how to develop environments that will encourage nurses to move along the continuum from mechanistic to individualised practice. The routinisation of practice is, however, currently reinforced by the separation of decision making from action in theories of accountability. Accountability is a crucial construct of professionalisation, and implies the authority to act autonomously within a defined sphere of competence (Batey and Lewis 1982). However, most formulations of accountability appear to equate autonomy with decision making about care, rather than the implementation of care. This implies that, providing decisions about care are taken by qualified nurses, they can be implemented by unqualified nurses. This fails, again, to recognise that decision making is an implicit component of all action, determining priorities and standards and resolving care dilemmas. The resolution of these decisions by unqualified nurses in accordance with a routine known to, and therefore sanctioned by the qualified staff lessens the

extent to which unqualified nurses can be held accountable for the consequences of the care they give. The routine therefore sets the standards and determines the priorities for care giving within a ward.

If nurses are to be encouraged to abandon this routine as they become more experienced, then the autonomy which underpins action at all levels must be acknowledged and encouraged. This suggests that if we wish to move away from routinised approaches to care, then we must recognise the potential of all staff to take decisions about care, and to sanction those decisions within defined parameters. This problem is highlighted by Maas, Specht and Jacox (1975), in their attempt to promote accountability within a nursing unit in a Veterans Hospital in the USA. Their experiences led them to recognise the need to develop a protocol for decision making and accountability for nursing aides (auxiliaries) within the unit, as well as for clerical staff.

The finding in this research, that decision making constitutes a component of all nursing care actions, appears to be central to the development of individualised care. Most formulations of individualised care identify the fulfilment of potential in patients as a central aim of nursing care. In developing this aim, it is frequently recognised that this involves negotiating the aims of care with the patient, and allowing the patient to identify their

own goals of care (Seedhouse 1986, McMahon 1989). If this is to become a predominant aspect of nursing practice, then it would appear to be necessary to begin by promoting potential in the nurse in the context of practice. It is difficult to identify how a nurse can be expected to facilitate the promotion of autonomy in patients if she lacks autonomy in her own work situation, as, lacking autonomy, she must continuously refer to a more senior nurse or doctor before being able to negotiate or accept the patient's own definition of the situation.

This is reinforced by Pearson (1988), in his discussion of the organisation of care in the Burford and Oxford Nursing Development Units, where "the question of how to organise care delivery in such a way as to give authority, and thus clear personal accountability" (Pearson 1988 p.30) is seen to be crucial to the development of primary nursing. As Pearson suggests, there has been considerable rhetoric about autonomy in nursing practice, but little evidence that these problems are being realistically tackled within the ward situation. As the findings presented in this research suggest, these problems are clearly compounded by dependence on a transient and unqualified workforce, within a hierarchical nursing structure, which serves only to dissipate accountability for practice.

The recognition of the importance of autonomy for the nurse if she is to promote individualised care, also has implications for the introduction of support workers

following the implementation of Project 2000 (UKCC 1986). In the Burford and Oxford Nursing Development Units, care assistants are employed, they do not, however, give any direct care to patients on their own, but instead provide a support service for the nurse, fetching equipment, laying up clinical trays, and stocking up the ward (McMahon 1988). The findings of this research suggest that if this arrangement cannot be introduced on a ward, then like Maas, Specht and Jacox (1975) the nurses must consider the sphere within which the support worker can exercise autonomy, otherwise any care delegated to these workers will again conform to a routine. The role of the support worker therefore poses a central problem for nursing, if it wishes to use basic care as a platform for the development of skilled professional practice. Using this platform implies that basic care can no longer be delegated to unqualified staff.

ROUTINISATION: THE CONTRIBUTION MADE BY THIS RESEARCH

The routinisation of basic care described in this research is not new. In fact it dominates most research into this aspect of nursing (Bendall 1974, Lelean 1973, Jones 1975, Wright 1974, Norton et.al. 1975, Fretwell 1982, Pembrey 1980). Numerous explanations for the routinisation of care are given. Menzies (1967) suggests it provides a defence against the full impact of patient anxiety. Similarly Hall and Stacey (1979) suggest it imposes a separate identity on the patient, by creating discontinuity between the patient

as a person prior to admission, and the person the patient becomes following admission. Bendall (1974) Lelean (1973) Pembrey (1980) and Fretwell (1982) locate the problem very much in the organisation of care on the ward. They suggest that it arises from an autocratic approach to care which is reinforced by task allocation. Consequently, they advocate the introduction of democratic approaches to ward management which also utilise patient allocation and the nursing process.

These explanations focus on the organisation of care at ward level, and suggest that changes in the way care is organised and managed at this level will overcome many of the problems. Explanations of the routinisation of care which look beyond the ward to the structural organisation of the hospital are given by Alaszewski (1977) and Davies (1976). Alaszewski suggested that the movement of nurses during training was inconsistent with the development of therapeutic relationships between nurses and patients. At the same time he recognised that it provided no tangible benefits for the education of the nurse, as the experiences available on each ward were very similar. Davies recognised that the routine may well be functional in nursing, in that it facilitates control over the work process in an occupation characterised by persistent staff shortages and the need to depend on a transient, part-time, predominantly female workforce.

This research reinforces the work of Alaszewski and Davies,

but also questions many of the assumptions within nursing about the inevitability of transience as the only available method of organising staffing. Firstly, it highlights the atheoretical approach to nursing practice which dominates current methods of nurse manpower planning and suggests that the methods used actually reinforce transience. It also suggests that in doing this, such methods reduce the operational capabilities of a nurse to that of a novice.

Secondly, it indicates that transience is not necessarily linked to staff shortages, but primarily results from the fluctuations in the allocation of learners to hospital wards. The sisters on each of the research wards went to great lengths to maintain staffing stability by endeavouring to allocate the same number of nurses to early and late shifts respectively. The dependence on learners meant, that in practice, although the total number of nurses found on a shift remained fairly constant, the individuals who made up these numbers continuously changed. The organisation of staffing preferred by the sisters appeared to promote stability in overall numbers, rather than a good match between workload and available staff, which is the dominant consideration in most manpower systems.

Stability appeared therefore, to be the preferred option of the sisters. In the light of the analysis of the contribution made to care by learners, this option appeared to make good sense. The findings that the agenda for basic

nursing is controlled by people giving care, means that the sisters are only able to influence the care given by unqualified staff if they have some opportunity to orientate them to the specific needs of patients. This was unachievable given the high level of transience which characterised these wards.

This research suggests that nurse managers need to take the issue of staffing stability more seriously, and not assume that transience is an inherent product of a staffing shortage. Moreover, they need to recognise that nurses may be able to work more effectively, if greater emphasis is placed on promoting stability, rather than simply concentrating on attaining a good match between measurements of workload and the allocation of staff. Whilst in one sense efficient, this research would suggest that such a method of manpower planning renders most nurses ineffective.

METHODOLOGICAL CONSIDERATIONS AND IMPLICATIONS FOR FURTHER RESEARCH

Although this research was informed primarily by qualitative research methods, which are grounded in the interpretations of the respondents, it attempted to locate the findings in the wider context of developments in nursing knowledge, and the introduction of individualised care. In doing this, it attempted to test out some of the assumptions about individualised care, the nursing process, and systems of patient allocation contained in the literature. In order to address these questions the Delphi survey method was

utilized to develop aims of care which reflected a range of nursing needs for patients in three levels of dependency. These aims formed the basis of the observation schedules which were shared with the nurses during the course of observation. This method was developed in order to explore with the nurses the aims of care which they felt reflected the specific needs of a particular patient. This method provided a framework which made explicit the decisions taken by nurses about aspects of basic nursing care.

One of the difficulties encountered with this method was that the aims selected by the nurses for specific patients were governed by the contextual aspects of the situation, which was dominated by the ward routine. Therefore the nurses had difficulty in identifying the relevance of aims of care which differed substantially from the routine, for instance aims which gave patients control over their own illness. This problem was particularly apparent on the medical and surgical ward, which was dominated by therapeutic aims of care. It was less so on the geriatric ward, where the nurses supported patient control, but failed to implement this in practice. It appears, therefore, that while there is some generalised support for patient control over the aims of care, particularly in the non-acute area of geriatrics, and in the results of the de-contextualised survey of sisters/charge nurses, there was little evidence that these aims were pursued in practice.

The method described above was adopted in order to locate nursing practice within wider theoretical debates about individualised care. It enabled the priorities observed on the ward to be categorised under different concepts of health, and to identify the concepts which dominated the routine situation observed. The schedules did, therefore, provide a useful framework for categorising and analysing the data. It could be argued, however, that presenting the nurses with this framework influenced their understanding of the research, and "biased" the results by producing explanations that reflected the contents of the observation schedules, and not the nurses normal practice.

The over-whelming domination of practice by the routine meant however, that non-routine nursing actions were rare, when they occurred they were carefully noted on the observation schedule. They were invariably isolated incidents and not repeated. This tends to reinforce the work of Hunt (1987), Robinson (1987) and Schon (1983), who all highlight the difficulties inherent in attempting to change nursing practice.

However, it is possible that more complete data could have been collected using this method if the schedules had focused around one aspect of patient care such as dressing, feeding, or hygiene. This would have greatly reduced the length of time taken to complete the schedules and therefore not demanded quite so much of the nurses' time. It would also enable the aims of care identified in the schedules to

be analysed in relation to the contextualised situations in which they were observed to operate. Part of the difficulty experienced in analysing the data arose from the diverse range of patients observed, and the large number of different aims of care from which the nurses could choose. It was, therefore, difficult to find sufficient data around one particular aspect of nursing, from which the pattern of frameworks used by nurses in relation to contextual situations could emerge. A more longitudinal approach, which followed a patient from admission to discharge might also be beneficial to see if the aims of care alter as the context alters.

The adoption of this method, however, did provide a framework for analysing nursing priorities in relation to aims of care derived from different perspectives on health. It also indicated that the different perspectives may not be complementary, and therefore cannot always be simultaneously pursued. This seems to be important for both manpower research and research into quality assurance as it indicates that nursing actions are not neutral but in fact reflect theoretical perspectives which can be analysed. Research into nurse manpower planning and quality assurance must therefore make explicit the theoretical perspective which underpins any criteria used to monitor staffing levels or standards of care. It must also recognise that the criteria used may not complement the priorities for care in the clinical environment. Divergence from the stated criteria

may reflect different perspectives which may contain important elements not recognised in the monitoring tool.

The research, therefore, highlights the importance for manpower planning and quality assurance of making explicit the underlying theoretical perspective which informed the selection of monitoring criteria. It also indicates the need to take a neutral stand in relation to the findings, i.e. to recognise that divergence from the evaluative criteria only means that the framework used in the study was not being employed on the ward. It says nothing about which framework was being used and why.

Finally, the methodology also has implications for studying the introduction of individualised care. The difficulties experienced by the nurses in completing the observation schedules, and in identifying aims of care that differed markedly from the ward routine, even when these were made available, suggests that the process of individualising care is both more complex (ie. it encompasses aims of care which conflict with current practice) and more simple (ie. the concept of individualised care must inevitably be constrained by the organisational imperatives of the hospital setting) than the literature on the nursing process appears to imply.

If we return to the literature on decision making discussed in the previous chapter, it appears to suggest that some routine for decision making operates in most organisations.

This routine governs the choice of factors taken into account in making a given decision. This literature appears to suggest that the introduction of individualised care, as it is currently conceptualised, is something of a misnomer.

The discussion of individualised care in the first chapter suggested that most definitions focus on promoting potential in individual patients by enabling them to take control over their own goals of care. This implies that patients with overtly similar dependency levels or diagnosis could require very different approaches to care. These are determined by their own idiosyncratic traits, anxieties, ability to understand the situation, and aspirations. In practice the extent to which any large organisation can accommodate individual definitions and needs is probably limited.

Moreover, although patients were not interviewed in this research, observations were recorded on the acute wards, which indicated that patients sought information from each other on what was likely to happen to them during their hospital stay. It is suggested that patients themselves might wish to conform to the routine as they recognise that, for the most part, it achieves their ultimate goal of discharge.

On the non-acute ward the nurses were more concerned about how they could promote independence for long-stay patients within a hospital setting. They did however have great difficulty in operationalising the aims of care they

identified as appropriate to the needs of these patients. It appears that more research is required to develop operational definitions of what individualised care means in practice.

If we return to the discussion about the pervasive nature of routinised decision making in large organisations, given in Chapter Eight, it is possible to suggest that nursing decisions for basic care are still governed by routinised solutions emanating from medical definitions of health and illness, which define basic nursing care as unskilled. As the work of Parry and Morriss (1974) suggests, it is possible that nurses are working with inherited routines which reflect an unskilled definition of basic care, although in practice they may not support the consequences of these routines.

It is possible to suggest, that because these routines are derived from the medical model they provide qualified nurses with sets of considerations that they can use to take decisions about technical care, which is more closely related to the traditional medical definition of health and illness, than is basic care. This indicates that if nurses do want to move away from rigid approaches to basic care and towards the use of negotiation with the patient and expert judgement in the implementation of this care, then a similar set of considerations or decision rules, needs to be developed for this aspect of care.

The methodology developed in this research could usefully be used to elucidate these considerations by integrating research based knowledge with an analysis of practice. However, any further attempts to adopt this methodological approach needs to confront the dissonance between practice and the idealised notions of care outlined in the schedules, which at times rendered them inappropriate to to the types of care giving observed on the wards. Moreover the nurses experienced great difficulty in addressing the idealised notions of care contained in the schedules and at times probably avoided doing so. More thought, and much more piloting of these aspects of the research is required before this method can be used to provide a greater understanding of the nursing considerations which underpin the development of individualised approaches to care.

Further research into this area is therefore problematic because of the pervasive culture which surrounds the implementation of basic care. Clearly wards which do not take learners could be investigated. However, as Melia (1984) suggests, definitions of nursing are learnt during training, on wards which, by definition, are characterised by transience. Therefore a failure to observe individualised care on wards with a stable staffing population may simply reflect the transfer of learning from one situation to another. A better test would perhaps be to observe the work of District nurses in the community where the staffing structure appears to be more conducive to maintaining

continuity of care by qualified staff.

However, as Silverman (1984) found, the problem of discontinuity in staffing is not limited to nursing. It was observed to occur in out-patient clinics where patients could see a different doctor every time they attended the clinic. This, Silverman suggests, reflects the fact that NHS patients have a relationship with a medical team, rather than an individual practitioner. He argues that this can have positive benefits for the patient, in that their case is likely to be reviewed by more than one doctor, which may reduce the possibility of oversights. However, it also undermines the development of personalised care and possibly weakens the experiential process which both Schon (1983) and Benner (1984) suggest is crucial to the development of expertise.

Clearly a balance needs to be struck between the ideals of primary nursing, which advocate 24 hour accountability for care, and the realities of practice which means that during a 24 hour period a patient will be cared for by at least three different nurses. It would appear that further investigation into the issues raised in this research actually demands the development of controlled environments, where staff turnover is stabilised and where there is a high proportion of qualified nurses who are aware of, and committed to an exploration of these issues. It suggests, therefore, that we need many more units like the one set up at Oxford (Pearson 1988).

For those areas where such units cannot be developed, it is argued that the fragmentation and routinisation which characterise so much of nursing practice, and which has been repeatedly recognised to have deleterious consequences for care, arise in part from the structural organisation of hospital staffing. Confronted with this organisational structure, it is not enough to exhort nurses to do better, or even educate them about the consequences of the care they give. As the nurses in this research demonstrate, awareness at a generalised level is an insufficient basis for action at an operational level. Instead, managers must think creatively about how to develop environments that will support the nurses and permit them to act autonomously throughout every aspect of their care of patients. It is not suggested that this will in itself overcome the problems described in this research. What is suggested is that it will provide an environment that is conducive to the development of individualised care by those nurses who choose to pursue this end.

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APPENDIX A

MEMBERS OF THE RESEARCH STEERING GROUP

The Steering group was comprised of representatives from the following departments:-

Regional Health Authority

Nursing Research Liaison Officer

Nursing Officer (Planning)

Nursing Officer (Professional Education and Development)

Nursing Officer (Information)

Personnel Officer (Manpower Resources Unit)

Regional Statistician

Regional Computer Programmer

Institute of Manpower Studies, University of Sussex

Senior Researcher

Health Services Research Ubit, University of Kent

Lecturer

APPENDIX B

A comparison of the RCCS formula and the NR3 formula is set out below.

A) Speciality or Department	Ratio Nurses : Beds etc RCCS Formula	 NR3 Formula
General Medicine	1:2 1/4	1:2
General Surgery	1:2 1/4	1:2
Trauma Orthopaedic	1:2 1/4	1:2
Opthalmic Surgery	1:2 1/4	1:2
ENT Surgery	1:2 1/4	1:2
Radiotherapy	1:2 1/4	1:2
Gynaecology	1:2 1/4	1:2
Geriatric Assessment & Rehabilitation	1:2 1/4	-
Geriatric Long Stay	1:2 1/2	-
Geriatric	-	1:1.9
Psycho-geriatric	-	1:1.9
Private and Amenity	1:2 1/4	
Paediactric	1:1 1/2	1:1.2
Neuro and Cardiac Surgery	1:1	1:0.9
Special Investigations	1:1 1/2	-
Psychiatric - Short Stay	1:1 4/5	1:1.8
Psychiatric - Medium Stay	1:3	-
Mentally Ill "New Long Stay"	-	1:3
Mentally Ill "Old Long Stay"	-	1:3
Isolation	1:2 1/2	1:1.2
Chest Diseases	-	1:2
Dermatology	-	1:2
Neurology	-	1:2
Cardiology	-	1:2
Rheumatology/Rehabilitation	-	1:2
Urology	-	1:2
Plastic Surgery	-	1:2
Dental Surgery	-	1:2
Young Chronic Sick	-	1:1.5
Mental Handicap	-	1:1.5
Intensive Therapy		4:1
Coronary Care		3:5.1
Maternity		
First Stage)	-	1:1
Delivery)	-	
Special Care Baby Cots	-	1:1
Intensive Neonatal Care Cots	-	1.45
<u>Day Units</u>		
Geriatric Places	1:?	1:3
Psychogeriatric Places	-	1:8
Mentally Ill places	1:8	1:8
Mentally Ill (Children) places		1:5
OPD (exclusing maternity allowance)	1:5,000	
Day Case Wards beds	1:?	
Day case theatres	3:1	
Observation beds (24 hours) up to 5 bds	1:1	
up to 10 bds	1:1 1/2	
Accident and Emergency attendances	1:?,??	

A) Speciality or Department	RCCS	NR3
B) Annual Leave Sick Leave	10% 5 %	) 22%)
C) Teaching	8%	10%
Additional to A, B and C 37½ hr. week		6.25%
Grand Total Whole Time Equivalent		
In acute hospitals which are Nurse training hospitals the following mix of staff is recommended by the NR3 formula		
Trained 50% Intraining 35% Others 15%		

APPENDIX C

Survey of Schools of Nursing

An exploratory study of recruitment practices in the Regiona. Health Authority in which the research was conducted wa: undertaken early in the research. This appendix summarises th results of this survey. It provides the background informatio which contributed to the development of the aims of the research

During the course of the survey all fifteen Schools of Nursing i the Region which undertook general nurse training were visited b the researcher. An open-ended interview ranging from 1 - 4 hour was conducted in each School. An interview was requested with th Director of Nurse Education (DNE) and/or a member of staff wit responsibility for recruitment nominated by the DNE. Other staf in the school who were involved in recruitment were als interviewed, this was left to the discretion of the DNE. Th decision to focus on recruitment practices arose out of concern expressed by the Regional Nurse Managers at the beginning of th research. It also formed part of the original proposal for whic funding was given.

Table A outlines the people interviewed during the course o this survey.

TABLE A

People Interviewed During Survey Of Schools of Nursing

School	People interviewed in each School			
1	DNE	Allocation Officer	Senior Tutor	Administrator
2				HCO Recruitment
3	DNE	Allocation Officer		
4	DNE			
5	DNE			Careers Officer
6	DNE			
7	DNE		Senior Tutor	HCO Recruitment
8	Ast.DNE			
9	DNE	Allocation Officer		
10	DNE			HCO Recruitment
11	DNE			
12	DNE		Senior Tutor	Administrator
13		Allocation Officer	Senior Tutor	HCO
14	DNE			Application Off
15	DNE		2 Snr. Tutor	

* HCO = Higher Clerical Officer

The interviews were informal and open-ended. At each school the people being interviewed were given the opportunity To pursue areas of particular interest to them. This proved particularly useful as it produced a detailed exploration of a number of different areas raising points that could be further explored at subsequent interviews.

The interview schedule used and a summary of the main points to come out of each section of the interview is set out below.

Waiting List

Every interviewee was asked if there was a waiting list for places at the school and if so for which course. The following answers were obtained.

1.There had been a noticeable Rise in applicants to every school of Nursing in the Region over the past two to three years. This was for both student and pupil nurse training. Consequently every school was able to fill every course. The main reason the respondents gave for this was the economic recession, which the Country was experiencing at the time, which was accompanied by high levels of youth unemployment.

2.The length of the waiting list varied according to recruitment procedure used by the school. Following the increase in applications some schools had become more selective about who they recruited. Three schools had raised their minimum academic entry qualifications from 4 GCE 'O' levels to 5 in two cases, and 6 in one case. Six schools had increased the number of applicants they rejected at the application or interview stage of the recruitment process. The remaining six schools had not altered their selection criteria. As a result they were developing increasingly long waiting lists for commencement of training. Some applicants were being asked to wait two years from interview to starting training.

3.The excess of suitably qualified applicants to each school was a relatively new situation. Prior to 1976 a large number of schools indicated that they recruited as many as 50% of their learner nurses directly from overseas. In 1976 the Government introduced legislation which prohibited direct recruitment from overseas to any form of employment unless it could be proved that a British market did not exist. Seven schools indicated that following the introduction of this legislation they had experienced difficulties in obtaining sufficient recruits to fill every intake. One school dropped its academic entry requirements during this period, another school stated that it was experienced severe pressure from service side colleagues to recruit people it did not consider suitable, simply to make up the numbers. This situation did not exist in any school at the time of the survey though a number of respondents feared it might return if there

was an expansion in the economy. The pressure from servic colleagues during periods of recruitment difficulties illustrate the close links between education and manpower planning, an highlighted an area that became a major focus for the research.

Criteria Used to Determine Recruitment Levels

At each school those being interviewed were asked how the determined the number of learner nurses to recruit on eac intake.

The main criteria identified were:-

1.Capacity of the training District.

2.District Health Authority training budget.

In most cases the number of learner nurses recruited was derive primarily from historical precedent. The origins of whic frequently pre-dated those being interviewed, and so they were unable to explain how this initial level was arrived at.

One school had reduced recruitment of pupil nurses in response t a reduction in the Health District's demand for State Enrolle nurses.

Three schools had planned reductions in both pupil and student nurse recruitment levels. This had been negotiated with the service side and was introduced via a reduction in the proportio of the District's nursing budget set aside for training. In none of these cases was the reduction linked to any planned demand fo nurses. One school had cancelled a pupil nurse intake at very short notice because the District Nursing budget was overspent. Two other schools were successfully resisting similar pressure.

Introduction of the 37 Hour Week

Every school was asked if the number of learner nurses they recruited had altered following the introduction of the European Economic Community (EEC) Directives for training. They were also asked if recruitment levels had altered following the introduction of the 37 hour week.

One school had increased recruitment to both student and pupil nurse training following the introduction of the 37 hour week Two schools stated that the introduction of the 37 hour week had increased the length of training and this could result in a reduction in recruitment if extra funding was not provided. Two schools were in the process of increasing their recruitment levels when these changes were introduced, and so absorbed the extra demand they created. Similarly the introduction of a modular training programme enabled another school to absorb these changes. The remaining seven schools made minor adjustments to

their training programmes in response to these changes. This di not affect their recruitment levels.

Bottlenecks

Eight schools had identified clinical areas which were a important part of the General Nursing Council (now Englis National Board) training syllabus for which there was limite training capacity within the District. These clinical areas coul only accommodate a small number of learners at any one time. Thi had implications for the number of nurses a school could recrui and train.

Eight schools experienced this problem. They identified th following clinical areas as limiting their capacity for training

Paediatrics 6 schools
Accident and Emergency 2 schools
Obstetrics 4 schools
Psychiatry 2 schools
Theatres 2 schools
Community care services 1 school

Most schools experienced more than one bottleneck.

The syllabus for pupil nurse training did not include obstetric psychiatry or community care, consequently a number of school found it easier to increase recruitment to pupil nurse training.

The pressure created by the bottlenecks in clinical placement reduced the number of post-enrolled courses for conversion fro State Enrolled nurse to Registered General nurse that could b run by the schools. As it was precisely the areas listed abov that were required for clinical placements during a conversio course.

Number of Posts Available For Newly Qualified Nurses

Ten schools reported that during the District Health Authorit would be unable to find sufficient posts to employ every newl qualified nurse. This problem was primarily the result o restrictions on the nursing budget, rather than an ove production of qualified nurses. It again highlights the clos links between education and manpower planning. It illustrates th difficulties of planning recruitment levels up to four years i advance of qualifying, when budgets are set at much shorter tim scales, and are subject to very different kinds of pressures.

Only one teaching hospital was experiencing a shortage o qualified nurses at the time of the survey.

Geographic Catchment Areas of the Schools of Nursing

At each school the respondents were asked to identify the geographic area from which they recruited for student and for pupil nurse training. This question was prompted by concerns raised at a Regional level as to whether Districts and Region could be self-sufficient in meeting training needs. Given the particular problems with nursing budgets being experienced at the time, there was concern that the Region might be training nurses who then moved out of the area. It was felt that this was an expense the nursing budgets could not accommodate at that time.

Very little data was available within the Schools on this subject and the answers given were impressionistic. Most schools appeared to recruit nationally for student nurse training, and locally (within the DHA) to pupil nurse courses. The lack of substantive data with which to answer this data made any analysis difficult.

Careers Advice

Every school gave lectures to final year learner nurses on the career opportunities available to them when they qualified. This included information on post-registration courses. The tutors would also provide individual careers advice, when approached by a learner nurse. Careers advice was also available to qualified nurses working in the District.

Selection Procedure

At each school the respondents were asked to outline the criteria used to select candidates for training. A wide range of criteria were given. Most of the respondents admitted they felt uncertain about this area, and recognised there was very little foundation for the criteria they used. Selection was based on a personal assessment of the candidate by the people who conducted the interview. A number of respondents suggested they would appreciate further research into this area.

Mature Recruits

For the purpose of the interview mature recruits were defined as people over the age of 25 at the start of training. Every school recruited people over this age, though policies towards women with children varied from school to school.

Male Nurses

Every school recruited male nurses, primarily though not exclusively to student nurse training. Two schools said their

capacity to recruit male nurses was limited by a shortage o: people available to chaperon.

Records Kept in Each School

At each school the respondents were asked to provide details o: the data collected on learner nurses and the form in which it wa: kept. The interviews revealed that the schools kept a lot of ra\ data on learner nurses. However most of the data was collected a\ the request of the Region or GNC. It was only occasionall\ utilized by the District to inform the decision making process.

Every school collected data on wastage rates. However th collection of this data was not standardised therefore comparisor was difficult.

A detailed breakdown on the number of applicants, number o: people interviewed, number of people accepted for training, an number that finally commenced training, was kept by each school This reflected a request made earlier by the Regional Healt Authority to assess the need for a central processing system i nursing.

Information about the geographic origins of the learners, thei entry qualifications and other data such as age, sex and marita status, were kept on an individual reference card for eac learner. In each school these cards were filed alphabetically b intake. This form of data base severely inhibits the extent t which the different characteristics of learner nurses such as ag and entry qualifications can be correlated with performance. It therefore limits the use of information available within th school which could be used to examine recruitment practice within the school.

Polytechnic of the South Bank

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Department of Nursing and Community Health Studies
Head of Dept: Miss G M Owen M Phil BSc(Hons) SRN SCM HV Tutors Cert RNT FRCN

17th February, 1984

Ref: SP/LC

Dear

The Development of a Method of Incorporating into the Nursing Service Manpower Planning System the Effects on the Provision of Nursing Produced by the Dual Status of Nurse Learners as Trainees and Employees.

Thank you very much for agreeing to participate in the above research project. I enclose the survey for you to complete. I would be very grateful if you could return it to me by the 31st March, 1984. I enclose a stamped addressed envelope. If you are unable to complete the survey by this date could you please ring me on the above extension or leave a message on extension 2250 and we can arrange a more convenient date.

The Survey

The survey consists of a description of three different patients 1, 2 and 3. You are asked in the survey to describe the responsibilities of the nursing staff in identifying and meeting the nursing needs of the patient on the basis of the information given.

No medical/surgical diagnosis is given because we feel that the patients' needs described in the survey apply to patients with a variety of different medical/surgical conditions. In the survey we have identified a range of problems commonly experienced by patients as a result of ill health. We are interested in identifying the nursing care required by patients who experience these problems regardless of the underlying medical/surgical diagnosis.

The answers you give will be kept totally confidential. It will not be possible for anyone to identify your answer during the course of the research or when it is written up.

It will probably be necessary to do a follow up survey in about May. The second survey should, however, be much simpler than the first and therefore should not take up so much of your time.

When the research is completed in about April 1985, the findings will be disseminated throughout the South East Thames Region. I would very much like to send everyone who has participated in the research a copy of the findings.

.....2.

17th February, 1984

However, financial constraints may prohibit this, in which case I will let you know how to obtain a copy of the findings should you be interested in following the research up.

I would be extremely grateful if you could complete the enclosed survey. The greater the number of replies I receive, the more the research will be grounded in the knowledge and working experience of Ward Sisters and Charge Nurses.

If you do have any further queries please do not hesitate to contact me at the Polytechnic of the South Bank. I look forward to hearing from you.

Yours sincerely,

Susan Procter S.R.N., B.Sc.
Research Fellow.

You have on your ward a patient who is unable to recognise his/her own daily needs and whose physical ability to attend to them is severely impaired. This patient has only a limited amount of movement in all four limbs and is unable to turn in bed without help. This patient has no ability, or awareness of the need to eat. This patient has no ability or awareness of the need to drink. This patient has no ability, or awareness of the need, to maintain personal hygiene. This patient is unable to indicate the need to pass urine. This patient is unable to indicate the need to evacuate his/her bowels. This patients colour is pale/bluish, his/her skin is clammy and some respiratory difficulties are apparent. This patient looks agitated and groans occasionally. This patient's spouse visits regularly.

Please describe the nursing care you think this patient requires.

Please give as much detail as possible.

List as many separate itmes of care as you think necessary.

You may describe more than one method of meeting a particular need.

No importance will be attached to the order in which you put the care items.

For every item of care described please give the reason why you think it should be given.

Please write on the back of the question sheet or use more paper if required.

PATIENT 1

Required Nursing

Reason for Care Specified

PATIENT 2

You have on your ward a patient who is able to recognise his/her own daily needs but whose physical ability to attend to them is limited. This patient is able to get out of bed and walk short distances with help. This patient has occasional pain and discomfort. This patient is physically able to eat and drink but has a variable poor appetite. This patient is continent of both faeces and urine but finds it physically difficult to get to the toilet. This patient needs some help with washing and bathing. This patient tries frequently to ask apparently trivial questions and apologises for being so demanding. This patient's relatives visit regularly.

Please describe the nursing care you think this patient requires.

Please give as much detail as possible.

List as many separate items of care as you think necessary.

You may describe more than one method of meeting a particular need.

No importance will be attached to the order in which you put the care items.

For every item of care described please give the reason why you think it should be given.

Please write on the back of the question sheet or use more paper if required.

PATIENT 2

Required Nursing	Reason for Care Specified

PATIENT 3

You have on your ward a patient that is in for investigations prior to treatment. He/she is fully alert, orientated and mobile. This patient is able to attend to all his/her own personal daily needs (washing, bathing, dressing, eating, drinking and eliminating). The patient's relatives visit regularly.

Please describe the nursing care you think this patient requires.

Please give as much detail as possible.

List as many separate items of care as you think necessary.

You may describe more than one method of meeting a particular need.

No importance will be attached to the order in which you put the care items.

For every item of care described please give the reason why you think it should be given.

Please write on the back of the question sheet or use more paper if required.

PATIENT 3

Nursing Required

Reasons for Care Specified

Please give any general comments

Thank you for your time, interest and help in completing this survey.
If you have any queries please contact me:-

Susan Procter
Department of Nursing and Community Health Studies, Polytechnic of the South Bank, Borough Road,
London SE1 OAA Telephone: 01 928 8989 ext 2126

Name of Patient _____ Dependency Category _____ Date _____ Grade of Nurse _____

AIMS OF CARE

COMMUNICATION SCORE 0

Instructions to nurse

Please identify the range of care in relation to communication that you intend this patient to receive today by ticking the appropriate boxes

Communication Score of patient = 0 (Always clear retains information, indicates needs)	Achieved	Not Necessary	Not Possible	Necessary	Care Required	Care Given	Grade of nurse giving care
Reassure the patient	☐	☐	☐	☐			
Discuss nursing care plan with patient	☐	☐	☐	☐			
Inform the patient of –							
Medical plan	☐	☐	☐	☐			
diagnosis	☐	☐	☐	☐			
progress	☐	☐	☐	☐			
investigations	☐	☐	☐	☐			
results	☐	☐	☐	☐			
likely outcome of care	☐	☐	☐	☐			
other (please state)							
Ensure understanding of information given	☐	☐	☐	☐			
Co-ordinate information given	☐	☐	☐	☐			
Enable the patient to –							
express anxiety	☐	☐	☐	☐			
ask questions	☐	☐	☐	☐			
Reduce anxiety levels	☐	☐	☐	☐			
Give realistic information about the expected outcome of care	☐	☐	☐	☐			

Name of Patient _____ Dependency Category _____ Date _____ Grade of Nurse _____

AIMS OF CARE

COMMUNICATION SCORE 1

Instructions to nurse

Please identify the range of care in relation to communication you intend this patient to receive today by ticking the appropriate boxes

Communication Score of patient = 1 (mostly indicates needs retains information')	Achieved	Not Necessary	Not Possible	Necessary	Care Required	Care Given	Grade of nurse giving care
Reassure the patient	☐	☐	☐	☐			
Discuss nursing care plan with patient	☐	☐	☐	☐			
Inform the patient of –							
Medical plan	☐	☐	☐	☐			
diagnosis	☐	☐	☐	☐			
progress	☐	☐	☐	☐			
investigations	☐	☐	☐	☐			
results	☐	☐	☐	☐			
likely outcome of care	☐	☐	☐	☐			
other (please state)							
Ensure understanding of information given	☐	☐	☐	☐			
Co-ordinate information given	☐	☐	☐	☐			
Enable the patient to.–							
express anxiety	☐	☐	☐	☐			
ask questions	☐	☐	☐	☐			
Reduce anxiety levels	☐	☐	☐	☐			
Identify patients needs	☐	☐	☐	☐			

Name of Patient _____ Dependency Category _____ Date _____ Grade of Nurse _____

AIMS OF CARE

COMMUNICATION SCORE 2

Instructions to nurse

Please identify the range of care in relation to communication you intend this patient to receive today oy ticking the appropriate boxes

Communication Score of patient = 2 (Cannot indicate needs or retain information, retains some expressive ability)	Achieved	Not Necessary	Not Possible	Necessary	Care Required	Care Given	Grade of nurse giving care
Reassure the patient	☐	☐	☐	☐			
Assess need for speech therapy	☐	☐	☐	☐			
Develop a communication code	☐	☐	☐	☐			
Talk to the patient	☐	☐	☐	☐			
Reduce anxiety levels	☐	☐	☐	☐			
Reduce frustration	☐	☐	☐	☐			
Give the patient information on:-							
Nursing plan	☐	☐	☐	☐			
Medical plan	☐	☐	☐	☐			
diagnosis	☐	☐	☐	☐			
progress	☐	☐	☐	☐			
investigations	☐	☐	☐	☐			
results	☐	☐	☐	☐			
Likely outcome of care	☐	☐	☐	☐			
other (please state)							
Co-ordinate information given	☐	☐	☐	☐			
Ensure understanding of information given	☐	☐	☐	☐			
Discuss nursing care plan with the patient	☐	☐	☐	☐			
Other (please state)							

Name of Patient _____ Dependency Category _____ Date _____ Grade of Nurse _____

AIMS OF CARE

COMMUNICATION SCORE 3

Instructions to nurse

Please identify the range of care in relation to communication you intend this patient to receive today by ticking the appropriate boxes

Communication Score of patient = 3 (no effective contact)	Achieved	Not Necessary	Not Possible	Necessary	Care Required	Care Given	Grade of nurse giving care
Reassure the patient	☐	☐	☐	☐			
Assess need for speech therapy	☐	☐	☐	☐			
Develop a communication code	☐	☐	☐	☐			
Talk to the patient	☐	☐	☐	☐			
Reduce anxiety levels	☐	☐	☐	☐			
Identify suitable topics of conversation	☐	☐	☐	☐			
Give the patient information on –							
Nursing plan	☐	☐	☐	☐			
Medical plan	☐	☐	☐	☐			
diagnosis	☐	☐	☐	☐			
progress	☐	☐	☐	☐			
investigations	☐	☐	☐	☐			
results	☐	☐	☐	☐			
Likely outcome of care	☐	☐	☐	☐			
other (please state)							
Co-ordinate information given	☐	☐	☐	☐			
Monitor level of consciousness	☐	☐	☐	☐			
Do not talk over the patients head	☐	☐	☐	☐			
Other (please state)							

Name of Patient _____ Dependency Category _____ Date _____ Grade of Nurse _____

AIMS OF CARE

FEEDING SCORE 0

Instructions to nurse

Please identify the range of care in relation to nutrition that you intend this patient to receive today by ticking the appropriate boxes

Feeding Patient score = 0 (Eats unaided)	Achieved	Not Necessary	Not Possible	Necessary	Care Required	Care Given	Grade of nurse giving care
Respect patients diet choices	☐	☐	☐	☐			
Provide a social environment at mealtimes	☐	☐	☐	☐			
Identify patients current dietary habits	☐	☐	☐	☐			
Enable patient to choose food desired	☐	☐	☐	☐			
Enable patient to eat at times of own choice	☐	☐	☐	☐			
Enable relatives/carers to bring food into patient	☐	☐	☐	☐			
Educate patient about a healthy diet	☐	☐	☐	☐			
Other (please state)							

Name of Patient _____ Dependency Category _____ Date _____ Grade of Nurse _____

AIMS OF CARE

FEEDING SCORE 1

Instructions to nurse

Please identify the range of care in relation to nutrition that you intend this patient to receive today by ticking the appropriate boxes

Feeding Patient score = 1 (needs aids)	Achieved	Not Necessary	Not Possible	Necessary	Care Required	Care Given	Grade of nurse giving care
Respect patients diet choices	☐	☐	☐	☐			
Provide a social environment at mealtimes	☐	☐	☐	☐			
Identify patients current dietary habits	☐	☐	☐	☐			
Enable patient to choose food desired	☐	☐	☐	☐			
Enable patient to eat at times of own choice	☐	☐	☐	☐			
Enable relatives/carers to bring food into patient	☐	☐	☐	☐			
Educate patient about a healthy diet	☐	☐	☐	☐			
Identify need for occupational therapy referral	☐	☐	☐	☐			
Identify aids required	☐	☐	☐	☐			
Develop a training programme for promoting independent feeding –							
with patient	☐	☐	☐	☐			
with occupational therapist	☐	☐	☐	☐			
with relatives/carers	☐	☐	☐	☐			
Evaluate progress please state frequency	☐	☐	☐	☐			
Assess need for referral to dietitian	☐	☐	☐	☐			
Prevent constipation	☐	☐	☐	☐			
Identify appropriate method for giving diet (ie oral, soft, liqued NG etc)	☐	☐	☐	☐			
Other (please state)							
HIGH DEPENDENCY PATIENTS ONLY							
Identify daily calorie and nutrition needs	☐	☐	☐	☐			
Identify daily fluid requirement	☐	☐	☐	☐			
Ensure patient consumes identified diet requirement	☐	☐	☐	☐			
Ensure patient consumes identified fluid requirements	☐	☐	☐	☐			
Other (please state)							

Name of Patient _____ Dependency Category _____ Date _____ Grade of Nurse _____

AIMS OF CARE

FEEDING SCORE 2

Instructions to nurse

Please identify the range of care in relation to nutrition that you intend this patient to receive today by ticking the appropriate boxes.

Feeding Patient score = 2 (needs help from one person)	Achieved	Not Necessary	Not Possible	Necessary	Care Required	Care Given	Grade of nurse giving care
Respect patients diet choices	☐	☐	☐	☐			
Provide a social environment at mealtimes	☐	☐	☐	☐			
Identify patients current dietary habits	☐	☐	☐	☐			
Enable patient to choose food desired	☐	☐	☐	☐			
Enable patient to eat at times of own choice	☐	☐	☐	☐			
Enable relatives/carers to bring food into patient	☐	☐	☐	☐			
Educate patient about a healthy diet	☐	☐	☐	☐			
Identify help required	☐	☐	☐	☐			
Assess need for occupational therapy referral	☐	☐	☐	☐			
Develop a training programme for promoting independent feeding –	☐	☐	☐	☐			
with patient	☐	☐	☐	☐			
with occupational therapist	☐	☐	☐	☐			
with relatives/carers	☐	☐	☐	☐			
Evaluate progress please state frequency	☐	☐	☐	☐			
Assess need for referral to dietitian	☐	☐	☐	☐			
Prevent constipation	☐	☐	☐	☐			
Identify appropriate method for giving diet (ie oral, soft, liqued, NG etc)	☐	☐	☐	☐			
Other (please state)							
HIGH DEPENDENCY PATIENTS ONLY							
Identify daily calorie and nutrition needs	☐	☐	☐	☐			
Identify daily fluid requirement	☐	☐	☐	☐			
Ensure patient consumes identified diet requirement	☐	☐	☐	☐			
Ensure patient consumes identified fluid requirements	☐	☐	☐	☐			
Other (please state)							

Name of Patient _____ Dependency Category _____ Date _____ Grade of Nurse _____

AIMS OF CARE

FEEDING SCORE 3

Instructions to nurse

Please identify the range of care in relation to nutrition that you intend this patient to receive today by ticking the appropriate boxes

Feeding Patient score = 3 (Has to be fully fed)	Achieved	Not Necessary	Not Possible	Necessary	Care Required	Care Given	Grade of nurse giving care
Identify help required	☐	☐	☐	☐			
Assess need for occupational therapy referral	☐	☐	☐	☐			
Develop a training programme for promoting independent feeding –							
with patient	☐	☐	☐	☐			
with occupational therapist	☐	☐	☐	☐			
with relatives/carers	☐	☐	☐	☐			
Evaluate progress please state frequency	☐	☐	☐	☐			
Assess need for referral to dietitian	☐	☐	☐	☐			
Prevent constipation	☐	☐	☐	☐			
Identify appropriate method for giving diet (ie. oral, soft, liqued. NG etc)	☐	☐	☐	☐			
Other (please state)							
HIGH DEPENDENCY PATIENTS ONLY							
Identify daily calorie and nutrition needs	☐	☐	☐	☐			
Identify daily fluid requirement	☐	☐	☐	☐			
Ensure patient consumes identified diet requirement	☐	☐	☐	☐			
Ensure patient consumes identified fluid requirements	☐	☐	☐	☐			
Other (please state)							
Identify appropriate form of diet:–							
Oral	☐	☐	☐	☐			
Naso-gastric	☐	☐	☐	☐			
Parental\intravenous	☐	☐	☐	☐			
Via gastrostomy	☐	☐	☐	☐			
Other (please state)							

Name of Patient _____ Dependency Category _____ Date _____ Grade of Nurse _____

AIMS OF CARE

BATHING SCORE 0

Instructions to nurse

Please identify the range of care in relation to bathing that you intend this patient to receive today by ticking the appropriate boxes.

Bathing Patient score = 0 ('No help needed')	Achieved	Not Necessary	Not Possible	Necessary	Care Required	Care Given	Grade of nurse giving care
Enable the patient to adhere to own hygiene routine	☐	☐	☐	☐			
Standard	☐	☐	☐	☐			
other (please state)							

Name of Patient _____ Dependency Category _____ Date _____ Grade of Nurse _____

AIMS OF CARE

BATHING SCORE 1

Instructions to nurse

Please identify the range of care in relation to bathing that you intend this patient to receive today by ticking the appropriate boxes.

Bathing Patient score = 1 (Needs aids)	Achieved	Not Necessary	Not Possible	Necessary	Care Required	Care Given	Grade of nurse giving care
Identify aids required	☐	☐	☐	☐			
Teach use of aids	☐	☐	☐	☐			
Enable patient to become independent in this aspect of care	☐	☐	☐	☐			
Enable patient to take decisions about care needs	☐	☐	☐	☐			
Enable the patient to adhere to own -							
Hygiene routine	☐	☐	☐	☐			
Standard	☐	☐	☐	☐			
other (please state)							
Assess need for occupational therapy refferal	☐	☐	☐	☐			
Maintain privacy	☐	☐	☐	☐			
Maintain dignity	☐	☐	☐	☐			
	☐	☐	☐	☐			
Maintain safety	☐	☐	☐	☐			
Other (please state)							

Name of Patient _____ Dependency Category _____ Date _____ Grade of Nurse _____

AIMS OF CARE

BATHING SCORE 2

Instructions to nurse

Please identify the range of care in relation to bathing that you intend this patient to receive today by ticking the appropriate boxes.

Bathing. Patient score = 2 (Needs help from one person)	Achieved	Not Necessary	Not Possible	Necessary	Care Required	Care Given	Grade of nurse giving care
Maintain safety	☐	☐	☐	☐			
Enable patient to become independent in this aspect of care	☐	☐	☐	☐			
Enable patient to take decisions about care needs	☐	☐	☐	☐			
	☐	☐	☐	☐			
Enable patient to control –							
Hygiene routine	☐	☐	☐	☐			
Standard	☐	☐	☐	☐			
other (please state)							
Assess need for occupational therapy referral	☐	☐	☐	☐			
	☐	☐	☐	☐			
Carry out occupational therapy regime	☐	☐	☐	☐			
Identify help needed	☐	☐	☐	☐			
Other (please state)							

Name of Patient _____ Dependency Category _____ Date _____ Grade of Nurse _____

AIMS OF CARE
BATHING SCORE 3
(LOW AND MEDIUM DEPENDENCY PATIENTS)

Instructions to nurse
Please identify the range of care in relation to bathing that you intend this patient to receive today by ticking the appropriate boxes.

Bathing Patient score = 3 ('Needs blanket bath') (Low and medium dependency patients only)	Achieved	Not Necessary	Not Possible	Necessary	Care Required	Care Given	Grade of nurse giving care
Enable patient to become independent in this aspect of care	☐	☐	☐	☐			
Enable patient to take decisions about care needs	☐	☐	☐	☐			
Identify help required	☐	☐	☐	☐			
Maintain safety	☐	☐	☐	☐			
Enable patient to control hygiene:-							
routine	☐	☐	☐	☐			
standard	☐	☐	☐	☐			
other (please state)							

Name of Patient _____ Dependency Category _____ Date _____ Grade of Nurse _____

AIMS OF CARE
BATHING SCORE 3
HIGH DEPENDENCY PATIENTS ONLY

Instructions to nurse
Please identify the range of care in relation to bathing that you intend this patient to receive today by ticking the appropriate boxes

Bathing Patient score = 3 (Needs blanket bath) (High dependency patients only)	Achieved	Not Necessary	Not Possible	Necessary	Care Required	Care Given	Grade of nurse giving care
Maintain patient's normal standard of appearance	☐	☐	☐	☐			
Adhere to normal hygiene routine	☐	☐	☐	☐			
Prevent skin breakdown	☐	☐	☐	☐			
Keep skin clean	☐	☐	☐	☐			
Keep hair clean	☐	☐	☐	☐			
Keep hair tidy	☐	☐	☐	☐			
Keep mouth clean	☐	☐	☐	☐			
Keep mouth moist	☐	☐	☐	☐			
Prevent oral infection	☐	☐	☐	☐			
Keep teeth/dentures clean	☐	☐	☐	☐			
Prevent tooth decay	☐	☐	☐	☐			
Keep nails clean	☐	☐	☐	☐			
Keep nails short	☐	☐	☐	☐			
Keep eyes clean	☐	☐	☐	☐			
Prevent corneal ulceration	☐	☐	☐	☐			
Prevent eye infections	☐	☐	☐	☐			
other (please state)							

Name of Patient _____ Dependency Category _____ Date _____ Grade of Nurse _____

AIMS OF CARE

SOCIABILITY SCORE 0

Instructions to nurse
Please identify the range of care in relation to sociability that you intend this patient to receive today by ticking the appropriate boxes

Sociability Patient score = 0 (Alert/sociable)	Achieved	Not Necessary	Not Possible	Necessary	Care Required	Care Given	Grade of nurse giving care
Provide stimulation	☐	☐	☐	☐			
Provide diversional therapy	☐	☐	☐	☐			
Reduce isolation	☐	☐	☐	☐			
Gain co-operation	☐	☐	☐	☐			
Promote patient control over illness	☐	☐	☐	☐			
other (please state)							

Name of Patient _____ Dependency Category _____ Date _____ Grade of Nurse _____

AIMS OF CARE

SOCIABILITY SCORE 1

Instructions to nurse

Please identify the range of care in relation to sociability that you intend this patient to receive today by ticking the appropriate boxes.

Sociability Patient score = 1 (Forgetful/vague)	Achieved	Not Necessary	Not Possible	Necessary	Care Required	Care Given	Grade of nurse giving care
Provide stimulation	☐	☐	☐	☐			
Provide diversional therapy	☐	☐	☐	☐			
Reduce isolation	☐	☐	☐	☐			
Gain co-operation	☐	☐	☐	☐			
Promote patient control over illness	☐	☐	☐	☐			
Orientate Patient	☐	☐	☐	☐			
other (please state)							

Name of Patient _____ Dependency Category _____ Date _____ Grade of Nurse _____

AIMS OF CARE

SOCIABILITY SCORE 2

Instructions to nurse

Please identify the range of care in relation to sociability that you intend this patient to receive today by ticking the appropriate boxes

Sociability Patient score = 2 (Apathetic/withdrawn)	Achieved	Not Necessary	Not Possible	Necessary	Care Required	Care Given	Grade of nurse giving care
Provide stimulation	☐	☐	☐	☐			
Provide diversional therapy	☐	☐	☐	☐			
Reduce isolation	☐	☐	☐	☐			
Gain co-operation	☐	☐	☐	☐			
Promote patient control over illness	☐	☐	☐	☐			
Orientate Patient	☐	☐	☐	☐			
other (please state)							

Name of Patient _____ Dependency Category _____ Date _____ Grade of Nurse _____

AIMS OF CARE

SOCIABILITY SCORE 3

Instructions to nurse

Please identify the range of care in relation to sociability that you intend this patient to receive today by ticking the appropriate boxes.

Sociability Patient score = 3 (Very confused)	Achieved	Not Necessary	Not Possible	Necessary	Care Required	Care Given	Grade of nurse giving care
Provide stimulation	☐	☐	☐	☐			
Provide diversional therapy	☐	☐	☐	☐			
Reduce isolation	☐	☐	☐	☐			
Gain co-operation	☐	☐	☐	☐			
Promote patient control over illness	☐	☐	☐	☐			
Reorientate the patient	☐	☐	☐	☐			
other (please state)							

Name of Patient _____ Dependency Category _____ Date _____ Grade of Nurse _____

AIMS OF CARE

CONTINENCE 0 (URINE)

Instructions to nurse

Please identify the range of care in relation to urinary continence that you intend this patient to receive today by ticking the appropriate boxes.

Continence (urine) Patient score = 0 ("Full control")	Achieved	Not Necessary	Not Possible	Necessary	Care Required	Care Given	Grade of nurse giving care
Maintain dignity	☐	☐	☐	☐			
Maintain privacy	☐	☐	☐	☐			
Identify patient's role in.-							
urine testing	☐	☐	☐	☐			
urine collections	☐	☐	☐	☐			
maintaining a fluid chart	☐	☐	☐	☐			
other (please state)							

Name of Patient _____ Dependency Category _____ Date _____ Grade of Nurse _____

AIMS OF CARE

CONTINENCE 1 (URINE)

Instructions to nurse

Please identify the range of care in relation to urinary continence that you intend this patient to receive today by ticking the appropriate boxes

Continence (urine) Patient score = 1 (occasional incontinence)	Achieved	Not Necessary	Not Possible	Necessary	Care Required	Care Given	Grade of nurse giving care
Maintain dignity	☐	☐	☐	☐			
Maintain privacy	☐	☐	☐	☐			
Identify cause of poor bladder control	☐	☐	☐	☐			
Identify pattern of incontinence	☐	☐	☐	☐			
Identify methods for controlling incontinence	☐	☐	☐	☐			
Identify methods for promoting continence	☐	☐	☐	☐			
Assess for suitable clothing	☐	☐	☐	☐			
Prevent pressure sores	☐	☐	☐	☐			
Identify aids required in toilet	☐	☐	☐	☐			
other (please state)							

Name of Patient . . . Dependency Category . . . . . Date _____ Grade of Nurse _____

AIMS OF CARE

CONTINENCE 2 (URINE)

Instructions to nurse

Please identify the range of care in relation to urinary continence that you intend this patient to receive today by ticking the appropriate boxes

Continence (urine) Patient score = 2 (Regular incontinence)	Achieved	Not Necessary	Not Possible	Necessary	Care Required	Care Given	Grade of nurse giving care
Maintain dignity	☐	☐	☐	☐			
Maintain privacy	☐	☐	☐	☐			
Identify cause of poor bladder control	☐	☐	☐	☐			
Identify pattern of incontinence	☐	☐	☐	☐			
Identify methods for controlling incontinence	☐	☐	☐	☐			
Identify methods for promoting continence	☐	☐	☐	☐			
Assess for suitable clothing	☐	☐	☐	☐			
Prevent pressure sores	☐	☐	☐	☐			
Catheterise the patient	☐	☐	☐	☐			
other (please state)							

Name of Patient _____ Dependency Category _____ Date _____ Grade of Nurse _____

AIMS OF CARE

CONTINENCE 3 (URINE)

Instructions to nurse

Please identify the range of care in relation to urinary continence that you intend this patient to receive today by ticking the appropriate boxes

Continence (mine) Patient score = 3 (Catheterised)	Achieved	Not Necessary	Not Possible	Necessary	Care Required	Care Given	Grade of nurse giving care
Maintain dignity	☐	☐	☐	☐			
Maintain privacy	☐	☐	☐	☐			
Prevent urinary tract infection	☐	☐	☐	☐			
Maintain closed drainage system	☐	☐	☐	☐			
Prevent urine reflux back into bladder	☐	☐	☐	☐			
Prevent trauma to neck of bladder	☐	☐	☐	☐			
Maintain bladder tone	☐	☐	☐	☐			
Prevent blocked catheter	☐	☐	☐	☐			
other (please state)	☐	☐	☐	☐			

Name of Patient _____ Dependency Category _____ Date _____ Grade of Nurse _____

AIMS OF CARE

CONTINENCE SCORE 0

Instructions to nurse

Please identify the range of care in relation to faecal continence that you intend this patient to receive today by ticking the appropriate boxes

Continence (faeces) Patient score = 0 (Full control)	Achieved	Not Necessary	Not Possible	Necessary	Care Required	Care Given	Grade of nurse giving care
Maintain dignity	☐	☐	☐	☐			
Maintain privacy	☐	☐	☐	☐			
Identify patient's role in:-							
stool collection	☐	☐	☐	☐			
maintaining a stool chart	☐	☐	☐	☐			
other (please state)							

Name of Patient _____ Dependency Category _____ Date _____ Grade of Nurse _____

AIMS OF CARE

CONTINENCE SCORE 1 (FAECES)

Instructions to nurse

Please identify the range of care in relation to faecal continence that you intend this patient to receive today by ticking the appropriate boxes.

Continence (faeces) Patient score = 1 (occasional incontinence)	Achieved	Not Necessary	Not Possible	Necessary	Care Required	Care Given	Grade of nurse giving care
Maintain dignity	☐	☐	☐	☐			
Maintain privacy	☐	☐	☐	☐			
Identify pattern of incontinence	☐	☐	☐	☐			
Identify cause of poor bowel control	☐	☐	☐	☐			
Identify methods for controlling incontinence	☐	☐	☐	☐			
Identify methods for promoting continence	☐	☐	☐	☐			
Prevent pressure sores	☐	☐	☐	☐			
other (please state)							

Name of Patient _____ Dependency Category _____ Date _____ Grade of Nurse _____

AIMS OF CARE

CONTINENCE SCORE 2 (FAECES)

Instructions to nurse
Please identify the range of care in relation to faecal continence that you intend this patient to receive today by ticking the appropriate boxes

Continence (faeces) Patient score = 2 (Regular Incontinence)	Achieved	Not Necessary	Not Possible	Necessary	Care Required	Care Given	Grade of nurse giving care
Maintain dignity	☐	☐	☐	☐			
Maintain privacy	☐	☐	☐	☐			
Identify pattern of incontinence	☐	☐	☐	☐			
Identify cause of poor bowel control	☐	☐	☐	☐			
Identify methods for controlling incontinence	☐	☐	☐	☐			
Identify methods for promoting continence	☐	☐	☐	☐			
Prevent pressure sores	☐	☐	☐	☐			
other (please state)							

Name of Patient _____ Dependency Category _____ Date _____ Grade of Nurse _____

AIMS OF CARE

MOBILITY SCORE 0

Instructions to nurse.

Please identify the range of care in relation to mobility that you intend this patient to receive today by ticking the appropriate boxes

Mobility Patient score = 0 (walks unaided)	Achieved	Not Necessary	Not Possible	Necessary	Care Required	Care Given	Grade of nurse giving care
Ensure the patient knows the location of –							
Bathroom	☐	☐	☐	☐			
Toilet	☐	☐	☐	☐			
Dayroom	☐	☐	☐	☐			
Ward kitchen	☐	☐	☐	☐			
Patient shop	☐	☐	☐	☐			
Other (please state)							

Name of Patient _____ Dependency Category _____ Date _____ Grade of Nurse _____

AIMS OF CARE

MOBILITY SCORE 1

Instructions to nurse

Please identify the range of care in relation to mobility that you intend this patient to receive today by ticking the appropriate boxes

Mobility Patient score = 1 (walks with help)	Achieved	Not Necessary	Not Possible	Necessary	Care Required	Care Given	Grade of nurse giving care
Ensure safety	☐	☐	☐	☐			
Ensure well fitting shoes	☐	☐	☐	☐			
Identify help required with walking	☐	☐	☐	☐			
aids	☐	☐	☐	☐			
nursing assistance	☐	☐	☐	☐			
Aim to obtain maximum walking capacity	☐	☐	☐	☐			
Aim to set realistic goals	☐	☐	☐	☐			
Assess need for physiotherapy referral	☐	☐	☐	☐			
Carry out physiotherapy regime	☐	☐	☐	☐			
Assess need for occupational therapy referral	☐	☐	☐	☐			
Carry out occupational therapy regime	☐	☐	☐	☐			
Aim to review progress (please state frequency)	☐	☐	☐	☐			
Aim to review goals (please state frequency)	☐	☐	☐	☐			
Maintain muscle tone	☐	☐	☐	☐			
Prevent muscle contractures	☐	☐	☐	☐			
Other (please state)							
Toileting (continent patients only)							
Identify means by which patient obtains access to toilet facilities							
day	☐	☐	☐	☐			
night	☐	☐	☐	☐			
Identify method for contacting nurse	☐	☐	☐	☐			
Other (please state)							

Name of Patient _____ Dependency Category _____ Date _____ Grade of Nurse _____

AIMS OF CARE

MOBILITY SCORE 2

Instructions to nurse

Please identify the range of care in relation to mobility that you intend this patient to receive today by ticking the appropriate boxes.

Mobility Patient score = 2 (chairbound)	Achieved	Not Necessary	Not Possible	Necessary	Care Required	Care Given	Grade of nurse giving care
Ensure safety Identify correct height for – bed	☐	☐	☐	☐			
chair	☐	☐	☐	☐			
Identify number of nurses required to transfer patient from bed to chair	☐	☐	☐	☐			
from chair to bed	☐	☐	☐	☐			
Identify aids required to transfer patient	☐	☐	☐	☐			
Assess condition of pressure areas – on admission	☐	☐	☐	☐			
regularly (please state frequency)	☐	☐	☐	☐			
record assessment (please state frequency)	☐	☐	☐	☐			
Prevent pressure sores	☐	☐	☐	☐			
using nursing care	☐	☐	☐	☐			
using aids	☐	☐	☐	☐			
Assess need for physiotherapy referral	☐	☐	☐	☐			
Carry out physiotherapy regime	☐	☐	☐	☐			
Assess need for occupational therapy referral	☐	☐	☐	☐			
Carry out occupational therapy regime	☐	☐	☐	☐			
Aim to set realistic goals	☐	☐	☐	☐			
Aim to review goals (please state frequency)	☐	☐	☐	☐			
Prevent DVT	☐	☐	☐	☐			
Maintain posture	☐	☐	☐	☐			
Maintain muscle tone	☐	☐	☐	☐			
Prevent muscle contractures	☐	☐	☐	☐			
Other (please state)							
Toileting (continent patients only)							
Identify means by which patient obtains access to toilet facilities							
day	☐	☐	☐	☐			
night	☐	☐	☐	☐			
Identify method for contacting nurse	☐	☐	☐	☐			
Other (please state)							

Name of Patient _____ Dependency Category _____ Date _____ Grade of Nurse _____

AIMS OF CARE

MOBILITY SCORE 3

Instructions to nurse

Please identify the range of care in relation to mobility that you intend this patient to receive today by ticking the appropriate boxes.

Mobility Patient score = 3 (bedfast)	Achieved	Not Necessary	Not Possible	Necessary	Care Required	Care Given	Grade of nurse giving care
Ensure safety	☐	☐	☐	☐			
Assess condition of pressure areas –							
on admission	☐	☐	☐	☐			
regularly (please state frequency)	☐	☐	☐	☐			
	☐	☐	☐	☐			
record assessment (please state frequency)	☐	☐	☐	☐			
Prevent pressure sores	☐	☐	☐	☐			
using nursing care	☐	☐	☐	☐			
using aids	☐	☐	☐	☐			
Assess need for physiotherapy referral	☐	☐	☐	☐			
Carry out physiotherapy regime	☐	☐	☐	☐			
Assess need for occupational therapy referral	☐	☐	☐	☐			
Carry out occupational therapy regime	☐	☐	☐	☐			
Aim to set realistic goals	☐	☐	☐	☐			
Aim to review goals (please state frequency)	☐	☐	☐	☐			
Prevent DVT and pulmonary embolism	☐	☐	☐	☐			
Prevent chest infection	☐	☐	☐	☐			
Maintain muscle tone	☐	☐	☐	☐			
Prevent muscle contractures	☐	☐	☐	☐			
Other (please state)							
Toileting. (continent patients only)							
Ensure safety	☐	☐	☐	☐			
Identify means by which patient obtains access to toilet facilities							
for elimination of urine	☐	☐	☐	☐			
for elimination of faeces	☐	☐	☐	☐			
Identify method for contacting nurse	☐	☐	☐	☐			
Other (please state)							

Name of Patient _____ Dependency Category _____ Date _____ Grade of Nurse _____

AIMS OF CARE

DRESSING SCORE 0

Instructions to nurse.

Please identify the range of care in relation to dressing that you intend this patient to receive today by ticking the appropriate boxes.

Dressing Patient score = 0 (Manages unaided)	Achieved	Not Necessary	Not Possible	Necessary	Care Required	Care Given	Grade of nurse giving care
Patient to dress in own clothes	☐	☐	☐	☐			
Patient to dress in hospital clothes	☐	☐	☐	☐			
other (please state)							

Name of Patient _____ Dependency Category _____ Date _____ Grade of Nurse _____

AIMS OF CARE

DRESSING SCORE 1

Instructions to nurse

Please identify the range of care in relation to dressing that you intend this patient to receive today by ticking the appropriate boxes.

Dressing Patient score = 1 (Needs aids)	Achieved	Not Necessary	Not Possible	Necessary	Care Required	Care Given	Grade of nurse giving care
Identify aids required	☐	☐	☐	☐			
Enable patient to become independent in this aspect of care	☐	☐	☐	☐			
Assess need for occupational therapy referral	☐	☐	☐	☐			
Develop training programme for dressing –							
with patient	☐	☐	☐	☐			
with occupational therapist	☐	☐	☐	☐			
with relatives/carers	☐	☐	☐	☐			
Evaluate progress (please state frequency)	☐	☐	☐	☐			
Identify adaptations required to clothes	☐	☐	☐	☐			
Maintain dignity	☐	☐	☐	☐			
Maintain privacy	☐	☐	☐	☐			
Maintain individuality	☐	☐	☐	☐			
Ensure a supply of clean clothes –							
from relatives/carers	☐	☐	☐	☐			
from hospital laundry	☐	☐	☐	☐			

Name of Patient _____ Dependency Category _____ Date _____ Grade of Nurse _____

AIMS OF CARE

DRESSING SCORE 2

Instructions to nurse

Please identify the range of care in relation to dressing that you intend this patient to receive today by ticking the appropriate boxes

Dressing Patient score = 2 (Needs some help from one person)	Achieved	Not Necessary	Not Possible	Necessary	Care Required	Care Given	Grade of nurse giving care
Identify aids required	☐	☐	☐	☐			
Enable patient to become independent in this aspect of care	☐	☐	☐	☐			
Assess need for occupational therapy referral	☐	☐	☐	☐			
Develop training programme for dressing –							
with patient	☐	☐	☐	☐			
with occupational therapist	☐	☐	☐	☐			
with relatives/carers	☐	☐	☐	☐			
Evaluate progress (please state frequency)	☐	☐	☐	☐			
Identify adaptations required to clothes	☐	☐	☐	☐			
Maintain dignity	☐	☐	☐	☐			
Maintain privacy	☐	☐	☐	☐			
Maintain individuality	☐	☐	☐	☐			
Ensure a supply of clean clothes –							
from relatives/carers	☐	☐	☐	☐			
from hospital laundry	☐	☐	☐	☐			

Name of Patient _____ Dependency Category _____ Date _____ Grade of Nurse _____

AIMS OF CARE

DRESSING SCORE 3

Instructions to nurse

Please identify the range of care in relation to dressing that you intend this patient to receive today by ticking the appropriate boxes

Dressing Patient score = 3 (Must be fully dressed)	Achieved	Not Necessary	Not Possible	Necessary	Care Required	Care Given	Grade of nurse giving care
Keep patient warm	☐	☐	☐	☐			
Assess need for occupational therapy referral	☐	☐	☐	☐			
Identify adaptations required to clothes	☐	☐	☐	☐			
Maintain dignity	☐	☐	☐	☐			
Maintain privacy	☐	☐	☐	☐			
Maintain individuality	☐	☐	☐	☐			
Ensure a supply of clean clothes –							
from relatives/carers	☐	☐	☐	☐			
from hospital laundry	☐	☐	☐	☐			

A DESCRIPTION OF THE RESEARCH DISTRICT AND RESEARCH WARD

The Research District

This District does not teach medical students and is outside the Greater London area. It is centred in a provincial town and provides health care for a population of about 185,000. The population is gradually increasing in size. About half the population live in the town and the immediate suburbs, the remainder are sparsely distributed over a large rural area. The population has a socio-economic distribution skewed towards higher social groups and a relatively low over 65 age group population.

A new District General Hospital (DGH) had recently been built in the District. At the time of the observation study, the first phase of the hospital had been completed and services had been provided from this site for about a year. The second phase of the hospital was still under construction.

The nurse training school was adjacent to the new DGH. At the start of the research it offered training for registration and enrolment in general nursing and in mental health. During the course of the research enrolled nurse training was discontinued following the publication of the ENB consultation paper into nurse education (ENB 1982). The last intake of pupil nurses were still completing their course at the time of observation.

A modular programme of training was in operation at the school, in which allocation to training wards was identified at the beginning of the course. However the Allocation Officer acknowledged that the current system created peaks and troughs in the secondment of learners to wards. A computer system was being developed in the District to produce a more even distribution in the flow of learners to these wards.

A Description of the Long-Stay Geriatric Ward

The ward had 36 beds arranged in the nightingale design. (see ward plan). The ward was selected for the research by the Nursing Officer at the hospital. The Sister was approached by the researcher and agreed to take part in the research. One team of doctors headed by a consultant were responsible for the medical care of patients on the ward. Ward rounds were held at fortnightly intervals. The nurses could contact the medical staff if they were required between ward rounds. The nurses were supported by the following services.

A housekeeping team was attached to the ward, their responsibilities included cleaning the ward, serving all meals to the patients including tea and coffee.

Meals were provided from a trolley which was sent to the ward at set times each day.

The ward had a fully equipped kitchen including cooker fridge tea and coffee making facilities.

Laundry was topped up each day. Day clothes were supplied for all the patients from a central pool, and washed in the laundry.

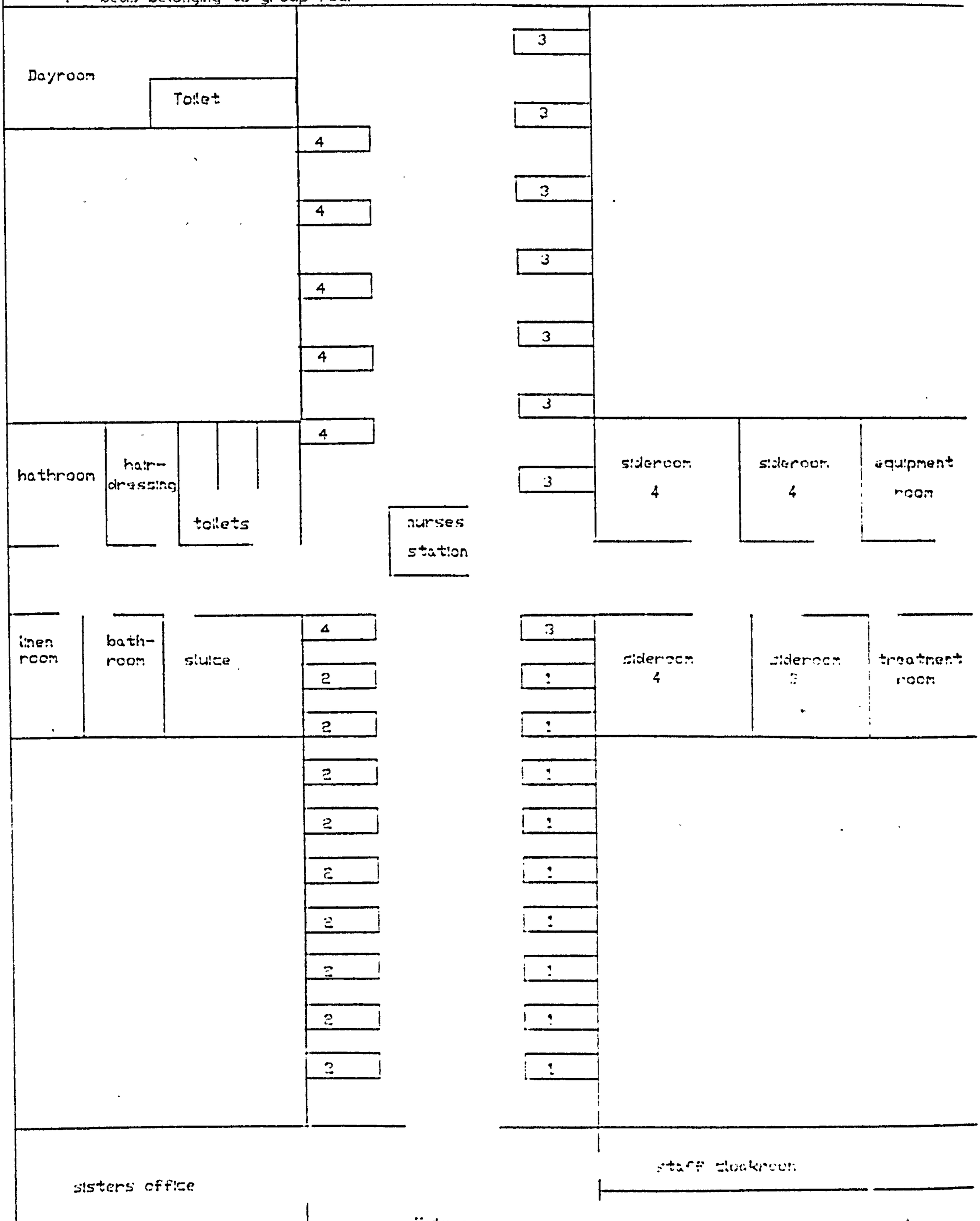
Occupational Therapy services were available at the hospital, many of the patients attended this department on a regular basis.

A district dietitian could be contacted on request.

A Community Liaison Officer for nursing services had just taken up post and could be contacted to facilitate transfer of patients between home and hospital.

WARD PLAN - GERIATRIC WARD

1 = beds belonging to group one
2 = beds belonging to group two
3 = beds belonging to group three
4 = beds belonging to group four



A Description of the Medical Ward

The ward has 28 beds arranged in a series of bays and siderooms (see ward plan). Three teams of doctors headed by a consultant was attached to the ward. The nurses are supported by the following services:-

A ward clerk worked part time on the ward, her main dutie included locating patients notes and x-rays, completing th paperwork associated with admission and discharge to and from th ward, and answering the phone.

A dietitian was available for the whole district and could be contacted if required.

A plated meal service was provided for the wards, patients were asked to complete menu cards up to three days in advance of the meal required.

Physiotherapy was provided on the ward at the request of the nursing or medical staff.

A Diabetic Liaison Officer commenced employment while the research was being conducted.

A Community Liaison Officer was available for the whole District to organise the discharge of patients requiring community services.

The pharmacy was located on the site of the new DGH, a pharmacist visited the ward every day to top-up the existing ward stock and to identify prescriptions that were not available from the ward stock.

A domestic service was available to clean the ward. Laundry was topped up every day.

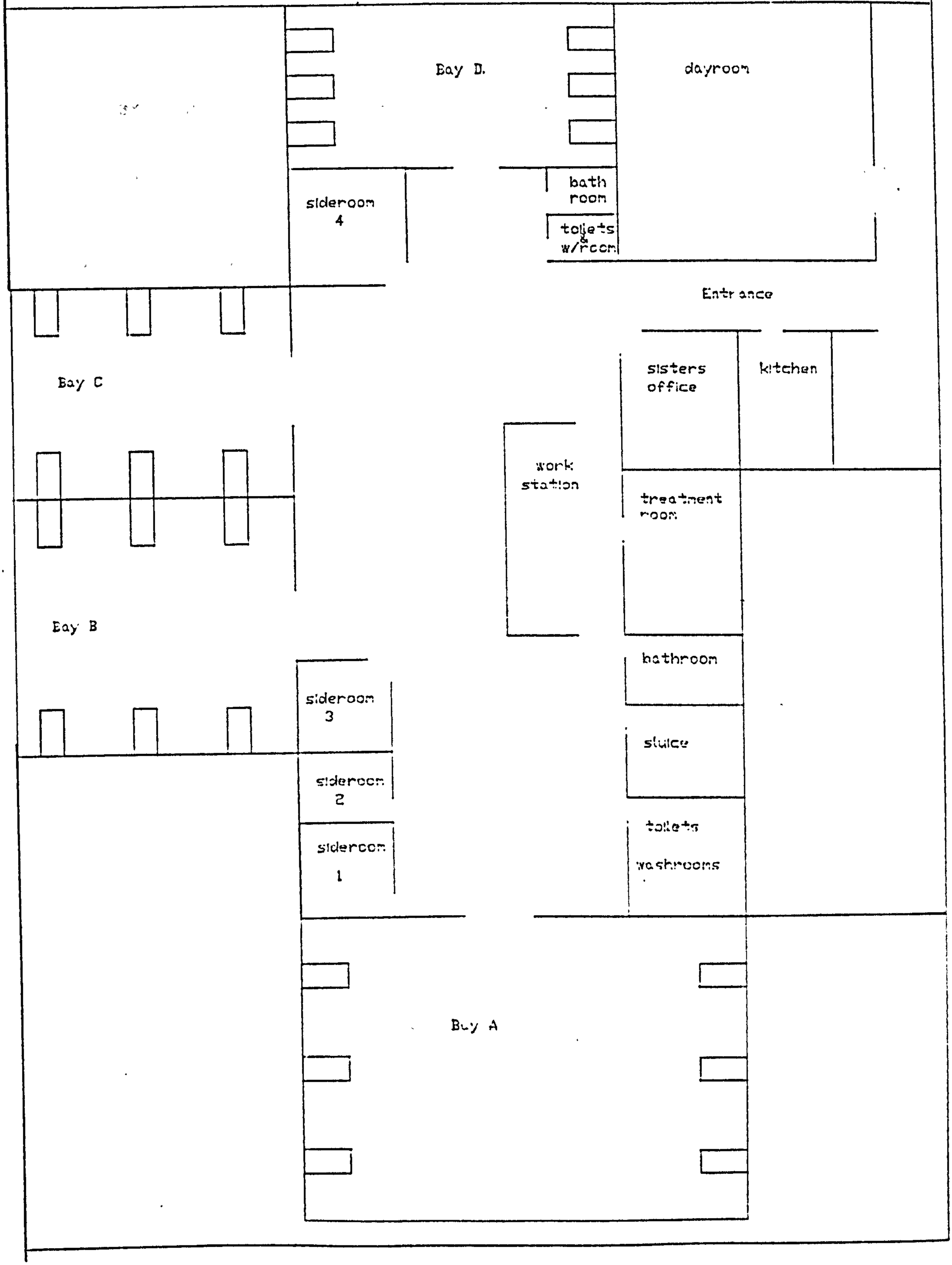
A central treatment suite was available in the hospital this undertook all dressings, and medical procedures requiring aseptic conditions but not general anaesthetic.

Occupational Therapy was not available on this site, patients requiring this service were transferred to hospitals where this service was available.

WARD PLAN - MEDICAL WARD

Team A. = Bay A, B & siderooms 1, 2 & 3

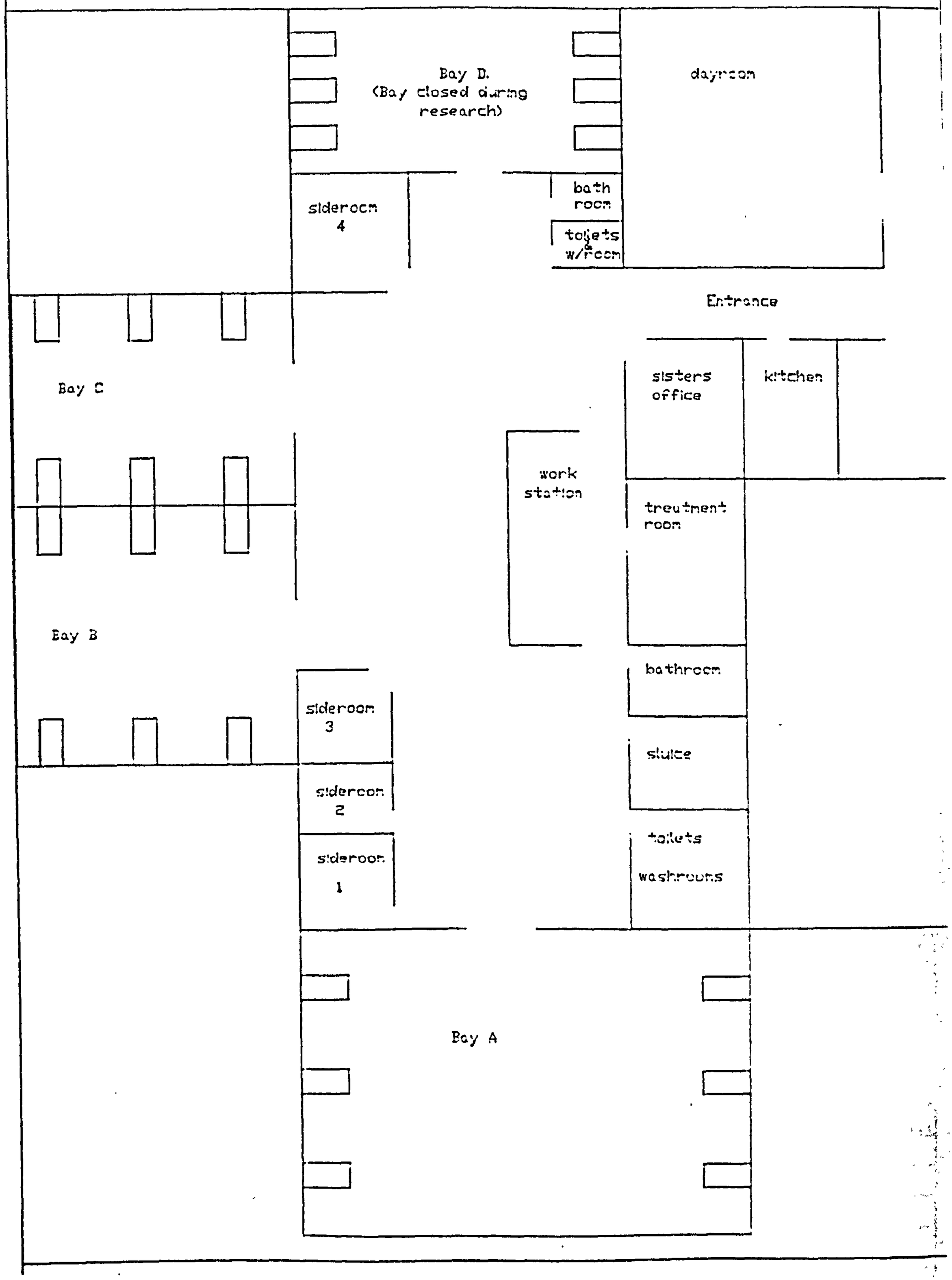
Team B. = Bay C, D & siderooms 4



A description of the Gynaecology Ward

The gynaecology ward had 22 beds arranged in a similar design to the medical ward (see ward plan). It took admissions direct from Accident and Emergency and from the waiting list. It had three teams of doctors each headed by a consultant. It was supported by the same services as the medical ward. The nurses on this ward did not use the central treatment suite for dressings as they preferred to undertake this aspect of patient care themselves.

WARD PLAN - SURGICAL WARD



APPENDIX G

ASSESSMENT OF LEVELS OF DEPENDENCY
TRANSFER OF CARE BETWEEN HOSPITAL AND COMMUNITY

PATIENT'S NAME ..... DATE OF BIRTH ..... WARD .....

HOME ADDRESS ..... HOSPITAL .....

PROGRESSIVE SCORING ASSESSMENTS OF CAPACITY TO COPE WITH DAILY LIVING ACTIVITIES

Low Dependency 0 - 15
Medium " 16 - 30
High " 31 - 45

Total score of 30 indicates cause for concern as does any single score of 2 or above.
Assessments should be carried out at regular agreed intervals.

A COMMUNICATION

Always clear, retains information, indicates needs. 0

Mostly indicates needs, retains information. 1

Cannot indicate needs or retain information, retains some expressive ability. 2

No effective contact. 3

B SOCIABILITY

Alert/Sociable. 0

Forgetful/Vague. 1

Apathetic/Withdrawn. 2

Very Confused. 3

C HEARING

Has good hearing without aid. 0

Has some loss of hearing. 1

Hears only with an aid. 2

Is completely deaf. 3

D SIGHT

Has good sight, does not wear glasses. 0

Sees well wearing glasses. 1

Sees poorly with glasses. 2

Is completely blind. 3

E MOBILITY

Walks unaided. 0

Walks with help. 1

Chairbound. 2

Bedfast. 3

F STAIRS

Climbs unaided. 0

Manages with aid (eg stick). 1

Needs help of one person. 2

Cannot manage at all. 3

G CONTINENCE (URINE)

Full control. 0

Occasional incontinence. 1

Regular incontinence. 2

Catheter. 3

H CONTINENCE (FAECES)

Full control. 0

Occasional incontinence. 1

Regular incontinence. 2

Colostomy. 3

I BATHING

No help needed. 0

Needs aid (rail, stool etc). 1

Needs some help from one person. 2

Needs blanket bath. 3

J DRESSING

Manages unaided. 0

Needs aid (eg long shoe horn. 1

Needs some help from one person. 2

Must be fully dressed. 3

K FEEDING

Eats unaided. 0

Needs aid (eg special cutlery). 1

Needs some help from one person. 2

Has to be fed fully. 3

L PREPARATION OF FOOD

Can make full meal. 0

Can make a snack. 1

Can get hot drink. 2

Unable to get any food/drink. 3

M HOME FACILITIES

Special Housing/Warden. 0

Bungalow/Grd Floor Flat. 1

Flat with lift. 2

Bed/Bathroom upstairs. 3

N LIVES WITH

Spouse/Companion. 0

Daughter/Son. 1

Others. 2

Alone. 3

O FAMILY/CARERS' CAPACITIES TO COPE

Can manage without help. 0

Need some help. 1

Need much help. 2

Unable to cope/no family/Carers. 3

ASSESSMENT PRIOR TO ADMISSION/REFERRAL

Ability to cope before admission/referral - Scores may have to be estimated from patients or carers' accounts.

Date	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	Total	Nurse's initials

PROGRESSIVE ASSESSMENT SCORING AFTER ADMISSION/REFERRAL - BY DIRECT OBSERVATION OF PATIENT

Above score to be used as baseline comparison with scored assessments after admission/referral - When possible by direct observation of patient doing activities.
For each single assessment put one number in appropriate column below.

Date	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	Total	Nurse's initials

Polytechnic of the South Bank

Borough Road
London SE1 OAA
01-928 8989

Faculty of Education Human & Social Studies
Department of Nursing & Community
Health Studies. Ext: 2079

7th October 1983

Dear Ward Sister/Charge Nurse,

The development of a method of incorporating into the Nursing Service Manpower Planning system the effects on the provision of nursing produced by the dual status of nurse learners as trainees and employees.

I am currently working with Maura Hunt (Nursing Research Liason Officer) on the above research project which is funded by the South East Thames Regional Health Authority. The aim of the research project is to identify the contribution made by learner nurses to the provision of nursing manpower. In order to undertake this project we need to develop criteria which could be used to assess the contribution made to patient care by learner nurses. However in searching for criteria to use we discovered that there was very little agreement over appropriate and acceptable standards by which the quality of care received by patients could be assessed. We felt a start needed to be made on this and that Ward Sisters/ Charge Nurses were the best people to contact as they are the experts in identifying and delivering direct patient care.

I am writing to ask if you would be prepared to take part in a survey which aims to identify acceptable standards of care for groups of patients. If you agree to take part you will be asked to state your views on aspects of patient care. This will be carried out by a postal survey and you will not have face to face contact with other people participating outside your ward area. The total responses received from all participants will be summarised and sent back to you. You will then be asked to refine your original response and answer further questions in the light of the summarised responses. In this way a group consensus on acceptable standards of nursing care will be developed. We anticipate that there will be about three rounds of questions and summaries with about two months between each round. At the end of the survey you will be sent the final results. As the responses are summarised it will not be possible at any stage for your individual response to be identified. If you do decide to participate, you should receive the first survey at about the end of November.

I would be very grateful if you would be prepared to participate in this survey. The greater the number of people involved the more the final outcome will reflect the knowledge and experience possessed by Ward Sisters/Charge Nurses working in a variety of different hospital environments.

I would therefore be very grateful if you could complete the enclosed form stating whether you are/are not prepared to participate in the survey and return it to me in the pre-paid envelope by the end of October 1983. On the form I have asked those who choose to participate to supply details of their home address. This is a precaution in case for any reason you are absent from work during any part of the survey as you will still be able to make a valuable contribution. Should you have any queries about this survey please don't hesitate to contact me at the Polytechnic of the South Bank.

I would be very grateful if you would be prepared to participate in this survey and I look forward to hearing from you.

Yours faithfully,

Susan Procter

Susan Procter SRN BSc
Researcher.

Department of Nursing
and Community Health Studies,
Polytechnic of the South Bank,
Borough Road,
London, SE1 0AA.

Tel:- 01 - 928 8931 ext 2079

The development of a method of incorporating into the Nursing Service Manpower Planning System the effects on the provision of nursing produced by the dual status of nurse learners as trainees and employees.

Please Complete Part A of the form

Please tick boxes as appropriate

PART A

I am willing to participate in the Survey ☐

I do not wish to participate in the Survey ☐

Name _____

Name of Ward _____

Hospital _____

Postal Address of Hospital _____

_____

_____

_____

Please tick appropriate boxes

Surgical Ward	mixed	☐	male	☐	female	☐
Medical Ward	mixed	☐	male	☐	female	☐
Geriatric Ward	mixed	☐	male	☐	female	☐
Coronary Care	mixed	☐	male	☐	female	☐
Intensive Care	mixed	☐	male	☐	female	☐
Neurology	mixed	☐	male	☐	female	☐
Neuro Surgery	mixed	☐	male	☐	female	☐

Cont'd....

Orthopaedic	mixed ☐	male ☐	female ☐
Plastic Surgery	mixed ☐	male ☐	female ☐
Urology	mixed ☐	male ☐	female ☐
E.N.T.	mixed ☐	male ☐	female ☐
Opthalmic	mixed ☐	male ☐	female ☐
Rheumatology	mixed ☐	male ☐	female ☐

Gynaecology

Other Please Specify _____ mixed ☐ male ☐ female ☐

Current Position held

Ward Sister	Senior ☐	Junior ☐
Charge Nurse	Senior ☐	Junior ☐

Would those who have chosen to participate complete Part B of the form (This is optional)

PART B

Home Address _____

_____

_____

_____

Please return completed form in pre-paid envelope by the end of October 1983 to:-

Susan Procter:- Department of Nursing and Community Health Studies,
Polytechnic of the South Bank,
Borough Road,
London, S.E.1. OAA

Tel:- 01 928 8989 ext: 2079

THE CLINICAL SPECIALITIES IN WHICH PARTICIPANTS IN THE DELPHI SURVEY WORKED

CLINICAL SPECIALITY	AGREED TO PARTICIPATE	RETURNED ROUND 1	RETURNED ROUND 2
Surgery	33	23	21
Geriatric	42	25	21
Medicine	53	29	26
ITU	9	5	5
Orthopaedic	13	6	5
Ophthalmic	4	1	1
Gynaecology	13	9	7
Neurology	2	1	-
Neurosurgery	1	1	1
Urology	5	2	2
Coronary Care	2	1	1
Liver Unit	2	1	1
Dental/ENT	3	2	2
Oncology	3	3	3
Trauma	2	2	2
Haematology	1	-	-
Dermatology	2	1	1
Young Disabled	1	-	-
Night Duty	3	1	1
Infection Control	1	-	-
In Service Training	1	-	-
TOTAL	196	113	100

Polytechnic of the South Bank

Borough Road
London SE1 0AA
01-928 8989
Ext.2126
Department of Nursing and Community Health Studies
Head of Dept: Miss G M Owen M Phil BSc(Hons) SRN SCM HV Tutors Cert RNT FRCN

SP/SK

17th August, 1984

Dear

The Development of a Method of Incorporating into the Nursing Service Manpower Planning System the Effects on the Provision of Nursing Produced by the Dual Status of Nurse Learners as Trainees and Employees

I enclose the second and final round of the survey for the above research project for you to complete. Before I explain what you have to do could I please apologise for the delay in sending this out. I hope this won't cause you too much inconvenience. Thank you very much for completing the first round, I realise it required a lot of work and time on your part and I am most grateful for all the work that you put into it.

The second round is not nearly so demanding. From the first round I have identified a range of aims of care thought applicable by most of the Sisters/Charge Nurses to nursing each patient described. The aims of care are arranged under the following headings:-

Communciation, Sociability, Mobility, Feeding, Dressing, Hygiene, Continence (urine faeces), Planning, Pain Control, Relatives/Carers, Respiration and Rest.

To check that I have correctly interpreted your replies to the first round I would be grateful if you could read through the aims of care listed under each heading for each patient. Could you then indicate, by ticking the appropriate box, whether you think that the aim is "necessary" or "not necessary" for nursing the patient described.

Cont/.....

I would be grateful if you could complete the second survey by 3 September, 1984. I enclose a stamped addressed envelope for your reply. If you are unable to complete this second survey by this date or have any other queries about it do not hesitate to contact me at the Polytechnic of the South Bank, a message can be left on ext 2250, if I am unavailable.

Thank you once again for all the work you have put into this research. I look forward to hearing from you.

Yours sincerely,

Susan Proctor

Susan Proctor S.R.N. B.Sc.
Research Fellow

Encs.

Patient One

PLANNING

Please read through the aims of care for planning for patient one, listed below. Please indicate, by ticking the appropriate box, whether you think the aims is "necessary" or "not necessary" for nursing the patient described.

	Necessary %	Not Necessary %	Don't Know %
Assess nursing needs of patient:-	80	0	20
on admission	98	1	1
at regular stated intervals	80	16	4
as condition changes	97	2	1
Involve relatives in assessment	89	10	1
Involve patient in assessment	41	52	7
Identify nursing care needs	94	1	5
From assessment	83	1	16
Involve relatives	90	9	1
Involve patient	47	48	45
Evaluate outcome of care given:-	74	4	22
at regular stated intervals	91	7	2
Involve relatives	87	10	3
Involve patient	47	42	11
other please state			

MOBILITY

Please read through the aims of care for mobility for patient one, listed below. Please indicate by ticking the appropriate box whether you think that the aim is "necessary" or "not necessary" for nursing the patient described.

	Necessary %	Not Necessary %	Don't Know %
Prevent pressure sores	99	0	1
using nursing care	96	2	2
using aids	93	5	2
Prevent Deep Vein Thrombosis and Pulmonary Embolism	97	3	0
Prevent Chest Infection	98	2	0
Prevent limb contractures	97	3	0
Maintain muscle tone	95	5	0
Prevent foot drop	97	3	0
Ensure safety	99	0	1
Assess need for physiotherapy referral	95	3	2
Assess need for occupational therapy referral	44	51	5
Carry out physiotherapy regime	92	4	3
Carry out occupational therapy regime	36	59	5
Assess condition of pressure areas	94	0	6
on admission	97	0	3
at regular stated intervals	97	0	3

	Necessary %	Not Necessary %	Don't Know %
Record assessment	87	0	12
at regular stated intervals	95	1	3

other please state

1 Page not completed

Patient No.

Continence Problem

Please read through the aims of care for continence (urine) for patient one, listed below. Please indicate, by ticking the appropriate box, whether you think that the aim is "necessary" or "not necessary" for nursing the patient described.

	Necessary %	Not necessary	Dc Kn
Identify cause of poor bladder control	84	14	
Identify pattern of incontinence	85	13	
Identify methods for controlling incontinence	95	3	
Identify methods for promoting continence	78	28	
Maintain privacy	99	0	
Maintain dignity	99	0	
Assess for suitable clothing	81	14	
Prevent pressure sores	99	0	
Identify aids required in toilet	48	48	
Assess need for catheterisation	97	1	
other please state			

CATHETERISED PATIENTS

Prevent urinary tract infection	98	0	
Maintain closed drainage system	95	2	
Prevent urine reflux back into bladder	96	1	
Prevent trauma to neck of bladder	93	2	
Maintain bladder tone	69	24	
Prevent blocked catheter	95	1	
other please state			

Patient One

CONTINENCE (FAECES)

Please read through the aims of care for continence (faeces) for patient one, listed below. Please indicate by ticking the appropriate box whether you think that the aim is "necessary" or "not necessary" for nursing the patient described.

	Necessary %	Not Necessary %	Don't Know %
Maintain dignity	100	0	0
Maintain privacy	100	0	0
Identify cause of poor bowel control	87	12	1
Identify pattern of incontinence	90	9	1
Identify methods for controlling incontinence	93	6	1
Identify methods for promoting continence	84	15	1
Prevent pressure sores	99	0	1
other please state			

DRESSING

Please read through the aims of care for dressing for patient one, listed below. Please indicate by ticking the appropriate box whether you think that the aim is "necessary" or "not necessary" for nursing the patient described.

	Necessary %	Not Necessary %	Don't Know %
Keep patient warm	98	1	1
Maintain dignity	99	0	1
Maintain privacy	99	0	1
Maintain individuality	92	5	3
Ensure supply of clean clothes:-			
from relatives/carers	74	21	5
from hospital laundry	83	14	3
Assess need for occupational therapy referral	43	51	6
Identify adaptations required to clothes	61	36	3
other please state			

Patient One

FEEDING

Please read through the aims of care for feeding for patient one, listed below. Please indicate by ticking the appropriate box whether you think that the aim is "necessary" or "not necessary" for nursing the patient described.

	Necessary %	Not Necessary %	Don't Know %
Identify daily calorie and nutrician needs	96	4	0
Identify daily fluid requirements	99	1	0
Assess need for referral to dietician	86	13	1
Ensure patient consumes identifed diet requirements	89	8	3
Ensure patient consumes identified fluid requirements	96	2	2
Identify appropriate form of diet:-			
oral	72	21	7
Naso-gastric	81	10	9
parental/intravenous	67	21	12
via gastrostomy	32	56	12
Identify help required with feeding	91	8	1
Assess need for occupational therapy referral	43	51	6
Prevent constipation	97	1	2
Identify patients current dietary habits from:-			
relatives/carers	88	11	1
patient	49	45	6
Enable relatives/carers to bring food into patient	70	28	2
other please state			

Patient One

HYGIENE

Please read through the aims of care for hygiene for patient one. Please indicate by ticking the appropriate box whether you think that the aim is "necessary" or "not necessary" to nursing the patient described.

	Necessary %	Not Necessary %	Don't Know %
Maintain patients normal standard of appearance	89	9	2
Adhere to normal hygiene routine	76	22	2
Prevent skin breakdown.	100	0	0
Keep skin clean	100	0	0
Keep hair clean	99	1	0
Keep hair tidy	98	0	2
Keep mouth clean	100	0	0
Keep mouth moist	100	0	0
Prevent oral infection	99	0	1
Keep teeth/dentures clean	99	1	0
Prevent tooth decay	74	18	8
Keep nails clean	99	1	0
Keep nails short	96	4	0
Keep eyes clean	100	0	0
Prevent corneal uiceration	94	5	1
Prevent eye infections	96	2	2
other please state			

Patient One

COMMUNICATION

Please read through the aims of care for communication for patient one, listed below. Please indicate, by ticking the appropriate box, whether you think that the aim is "necessary" or "not necessary" for nursing the patient described.

	Necessary %	Not Necessary %	Don't Know %
Reassure the patient	98	0	2
Assess need for speech therapy	65	32	3
Develop a communication code	93	7	0
Reduce anxiety levels	98	1	1
Give the patient information on:-			
nursing plan	80	19	1
medical care	68	29	3
diagnosis	48	46	6
progress	79	19	2
investigations	64	34	2
results	53	44	3
Likely outcomes of care	69	28	3
other please state			
Co-ordinate information given	83	9	8
Talk to the patient	100	0	0
Identify suitable topics of conversation	84	16	0
Monitor level of consciousness	97	2	1
Do not talk over the patients head	98	2	0
other please state			

Patient One

SOCIABILITY

Please read through the aims of care for sociability for patient one, listed below. Please indicate, by ticking the appropriate box, whether you think that the aim is "necessary" or "not necessary" for nursing the patient described.

	Necessary	Not Necessary	Don't Know
	%	%	%
Reorientate the patient	84	12	4
Motivate the patient	77	19	4
Provide stimulation	87	11	2
Provide divertional therapy	52	43	5
Reduce isolation	86	11	3
Gain co-operation	88	8	4
other please state			

Patient One

RESPIRATION

Please read through the aims of care for respiration for patient one, listed below. Please indicate by ticking the appropriate box whether you think the aim is "necessary" or "not necessary" for nursing the patient described.

	Necessary %	Not Necessary %	Don't Know %
Place patient in a position which:-			
facilitates chest expansion	98	1	1
prevents chest infection	96	1	3
prevents obstruction of the airway	98	1	1
Identify nursing care required to:-			
maintain clear airway	98	1	1
Assess need for physiotherapy referral	94	5	1
Carry out physiotherapy regime	93	7	0
Administer oxygen at correctly identified rate	93	6	1
Only administer oxygen if prescribed by Doctor	67	26	7
Identify method for administering oxygen	97	1	2
Identify methods for monitoring patients condition	97	1	2
Report changes in patients condition to medical staff	98	0	2
Give prescribed medication	100	0	0

Patient One

REST

Please read through the aims of care for rest for patient one. Please indicate by ticking the appropriate box whether you think that the aim is "necessary" or "not necessary" for nursing the patient described.

	Necessary %	Not Necessary %	Don't Know %
Maintain Circadian Rhythms	71	24	5
Prevent exhaustion of patient	92	4	4
Plan care to enable frequent periods of uninterrupted rest	97	1	2
Monitor sleeping patterns	77	19	4
Enable patient to obtain adequate sleep	94	6	0

Patient One

RELATIVES/CARERS

Please read through the aims of care for relatives for patient one, listed below. Please indicate, by ticking the appropriate box, whether you think that the aim is "necessary" or "not necessary" for nursing the patient described.

	Necessary %	Not Necessary %	Don't Know %
Reassure relatives/carers	95	0	5
Inform relatives/carers of:-			
diagnosis	96	2	2
prognosis	97	2	1
likely outcomes of care	97	1	2
progress	97	2	1
investigations	93	5	2
results	91	6	3
medical plan	92	4	4
other please state			
Ensure understanding of the information given	96	1	3
Co-ordinate information given	94	0	6
Enable relatives/carers to:-			
express anxiety	98	1	1
ask questions	98	0	2
Identify ways of involving relatives/ carers in care of patient	96	0	4
Ascertain whether or not relatives/ carers wish to participate in care	98	0	2
Assess need to refer relatives/carers to social worker/Chaplain or other forms of support	98	0	2
other please state			

Patient Two

PLANNING

Please read through the aims of care for planning for patient two, listed below. Please indicate by ticking the appropriate box whether you think the aim is "necessary" or "not necessary" for nursing the patient described.

	Necessary %	Not Necessary %	Don't Know %
Assess the nursing needs of the patient:-	78	0	22
on admission	96	2	2
at regular stated intervals	82	13	5
as condition changes	93	5	2
Involve patient in assessment of care needs	95	3	2
Involve relatives/carers in assessment of care needs	94	4	2
Aim to promote independence in each aspect of care	99	0	1
Identify methods of promoting independence in each aspect of care	97	0	3
Plan nursing care to be given	99	0	1
Involve patient in planning care	94	3	3
Involve relatives/carers in planning care	89	7	4
Evaluate progress	96	0	4
at regular stated intervals	92	4	4
Involve patient in the evaluation of progress	96	2	2
Involve relatives/carers in the evaluation of progress	87	8	5
Only involve relatives/carers in assessment, planning and evaluation of care if patient agress to their involvement	72	19	9

other please state

Patient Two

MOBILITY

Please read through the aims of care for mobility for patient two,listed below. Please indicate, by ticking the appropriate box, whether you think the aim is "necessary" or "not necessary" for nursing the patient described.

	Necessary	Not Necessary	Don't Know
Identify help required with walking:-	%	%	%
aids	98	1	1
nursing assistance	99	0	1
Ensure safety	100	0	0
Assess need for physiotherapy referral	98	2	0
Carry out physiotherapy regime	95	5	0
Assess need for occupational therapy referral	99	1	0
Carry out occupational therapy regime	95	5	0
Aim to obtain maximum walking capacity	96	3	1
Aim to set realistic goals	99	0	1
Aim to review goals	98	0	2
Aim to review progress	98	0	2
Identify correct height:-			
for chair	99	1	0
for bed	96	4	0
Identify number of nurses required to transfer patient:-			
from bed to chair	93	5	2
from chair to bed	95	4	1
Identify aids required to transfer patient	93	5	2
Assess condition of pressure areas:-			
on admission	98	0	2
at stated regular intervals	95	3	2

	Necessary %	Not Necessary %	Don't Know %
Prevent pressure sores:-	92	2	6
using nursing care	98	2	0
using aids	93	7	0
Prevent Deep Vein Thrombosis	95	5	0
Prevent Pulmonary Embolism	94	5	1
Maintain muscle tone	91	9	0
Prevent contractures	84	14	2
Maintain posture	90	5	5
other please state			

Patient Two

DRESSING

Please read through the aims of care for dressing for patient two, listed below. Please indicate by ticking the appropriate box whether you think that the aim is "necessary" or "not necessary" for nursing the patient described.

	Necessary %	Not Necessary %	Don't Know %
Identify aids required	93	5	2
Identify help required	98	0	2
Enable patient to become independent in this aspect of care	96	3	1
Assess need for occupational therapy referral	96	3	1
Develop training programme for dressing:-			
with patient	93	5	2
with occupational therapist	92	7	1
with relatives/carers	86	13	1
Evaluate progress	98	1	1
Identify adaptations required to clothes	93	5	2
Maintain dignity	99	0	1
Maintain privacy	99	0	1
Maintain individuality	98	0	2
Ensure supply of clean clothes:-			
from relatives/carers	95	2	3
from hospital laundry	55	36	9
other please state			

Patient Two

CONTINENCE (URINE)

Please read through the aims of care for continence (urine) for patient two, listed below. Please indicate, by ticking the appropriate box, whether you think that the aim is "necessary" or "not necessary" for nursing the patient described.

	Necessary	Not Necessary	Don't Know
Identify means by which the patient obtains access to toilet facilities:-	%	%	%
day	99	0	1
night	98	1	1
Identify method for contacting nurse	98	1	1
Identify aids required in toilet	98	1	1
Maintain privacy	98	1	1
Maintain dignity	99	0	1

Patient Two

CONTINENCE (FAECES)

Please read through the aims of care for continence (faeces) for patient two, listed below. Please indicate by ticking the appropriate box whether you think that the aim is "necessary" or "not necessary" for nursing the patient described.

	Necessary		Not Necessary		Don't Know	
Identify means by which the patient obtains access to toilet facilities:-		%		%		%
day	99		0		1	
night	96		3		1	
Identify method for contacting nurse	98		1		1	
Identify aids required in toilet	98		1		1	
Maintain privacy	99		0		0	
Maintain dignity	99		0		0	

Patient Two

HYGIENE

Please read through the aims of care for hygiene for patient two. Please indicate by ticking the appropriate box whether you think that the aim is "necessary" or "not necessary" to nursing the patient described.

	Necessary %	Not Necessary %	Don Kno %
Identify help needed	97	1	2
Maintain safety	99	0	1
Enable patient to take decision about care needs	96	3	1
Enable patient to become independent in this aspect of care	97	1	2
Enable patient to control hygiene:-			
routine	94	4	2
standards	95	2	3
Maintain privacy	98	0	2
Maintain dignity	97	1	2
Identify aids required	94	4	2
Teach use of aids	94	3	3
Assess need for occupational therapy referral	95	3	2
Carry out occupational therapy regime	92	6	2
other please state			

Patient Two

FEEDING

Please read through the aims of care for feeding for patient two, listed below. Please indicate by ticking the appropriate box whether you think that the aim is "necessary" or "not necessary" for nursing the patient described.

	Necessary %	Not Necessary %	Don't Know %
Enable patient to choose food desired	100	0	0
Enable patient to eat at times of own choice	58	31	11
Provide a social environment at meal times	91	8	1
Identify help required with feeding	80	20	0
Assess need for occupational therapy referral	77	22	1
Develop training programme to promote independent feeding:-			
with patient	81	19	0
with occupational therapist	64	35	1
with relatives/carers	78	22	0
Evaluate progress regularly	88	12	0
Identify aids required	79	20	1
Assess need for referral to dietician	96	3	1
Prevent constipation	100	0	0
Enable relatives/carers to bring food into patient	97	3	0
Identify patients current dietary habits	100	0	0
Educate patient about a healthy diet	95	5	0
Respect patients diet choices	99	0	1

other please state

Patient Two

COMMUNICATION

Please read through the aims of care for communication for patient two, listed below. Please indicate by ticking the appropriate box whether you think that the aim is "necessary" or "not necessary" for nursing the patient described.

	Necessary %	Not Necessary %	Don't Know %
Reassure the patient	92	0	8
Inform the patient of:-			
medical plan	93	5	2
diagnosis	82	11	6
progress	97	2	1
investigations	95	4	1
results	91	7	2
Likely outcomes of care	95	3	2
other please state			
Ensure understanding of the information given	98	0	2
Co-ordinate information given	96	2	2
Discuss nursing care plan with patient	95	4	1
Enable the patient to:-			
express anxiety	100	0	0
ask questions	100	0	0
Identify patients needs	100	0	0
Reduce anxiety levels	100	0	0
Reduce frustration	100	0	0
Give realistic information on the expected outcome of care	99	1	0
other please state			

Patient Two

SOCIABILITY

Please read through the aims of care for sociability for patient two, listed below. Please indicate, by ticking the appropriate box, whether you think that the aim is "necessary" or "not necessary" for nursing the patient described.

	Necessary	Not Necessary	Don't Know
	%	%	%
Provide stimulation	99	1	0
Provide Divertional therapy	94	5	1
Reduce isolation	96	3	1
Gain co-operation	100	0	0
Promote patient control over illness	94	5	1
other please state			

Patient Two

REST

Please read through the aims of care for rest for patient two, listed below. Please indicate, by ticking the appropriate box, whether you think that the aim is "necessary" or "not necessary" for nursing the patient described.

	Necessary %	Not Necessary %	Don't Know %
Maintain Circadian Rhythms	77	15	8
Plan rest periods	82	17	1
Plan rest periods in rehabilitation regime	95	5	0
Monitor sleeping patterns	80	17	3
Identify any difficulties with sleeping	100	0	0
Discuss difficulties with patient	100	0	0
Identify means of overcoming difficulties	100	0	0

other please state

Patient Two

PAIN CONTROL

Please read through the aims of care for pain control for patient two, listed below. Please indicate by ticking the appropriate box whether you think the aim is "necessary" or "not necessary" for nursing the patient described.

	Necessary %	Not Necessary %	Don't Know %
Identify method(s) for monitoring level of pain	89	1	10
Give analgesia:-	85	1	14
as prescribed by Doctor	95	2	3
at regular stated intervals	78	18	4
Aim to control pain	91	6	3
Aim to prevent pain	90	8	2
Discuss pain control with patient	97	2	1
Try and identify methods other than analgesia for controlling pain	94	2	4
Use any methods identified:-	78	5	17
only if patient agrees	88	8	2
Prevent drowsiness from analgesia	92	7	1
Identify effectiveness of analgesia	99	1	0
Report effectiveness to Doctor	99	1	0
Discuss pain control with Doctor	97	1	2
Give analgesia prior to any painful procedure	96	3	1
Try and identify cause of pain	100	0	0
Treat cause if identified	99	0	1
Inform patient of any side effect of analgesia	87	12	1

other please state

Patient Two

RELATIVES/CARERS

Please read through the aims of care for relatives/carers for patient two, listed below. Please indicate, by ticking the appropriate box, whether you think the aim is "necessary" or "not necessary" for nursing the patient described.

	Necessary %	Not Necessary %	Don't Know %
Reassure relatives/carers	97	0	3
Inform relatives/carers of:-			
diagnosis	90	6	4
progress	97	2	1
likely outcomes of care	97	2	1
investigations	91	7	2
results	90	7	3
medical plan	89	8	3
other please state			
Only give information to relatives/ carers if patient agrees	72	23	5
Co-ordinate information given	96	1	3
Enable relatives/carers to:-			
express anxiety	99	0	1
ask questions	99	0	1
Identify ways if involving relatives/ carers in care of patient	98	2	0
Only if relatives/carers wish to participate	90	7	3
Only if patient agrees to their participation	87	11	2
Plan discharge with relatives/carers	97	1	2
Assess need for referral to social worker	97	2	1
other please state			

Patient Three

PLANNING

Please read through the aims of care for planning for patient three. Please indicate, by ticking the appropriate box, whether you think the aim is "necessary" or "not necessary" for nursing the patient described.

	Necessary %	Not Necessary %	Don't Know %
Assess the nursing needs of the patient:-	82	4	14
on admission	88	6	6
at regular stated intervals	55	36	9
as condition changes	84	9	7
Involve patient in the assessment of care needs	92	5	3
Involve relatives/carers in the assessment of care needs	55	40	5
Plan nursing care to be given	93	6	1
Involve patient in planning care	95	4	1
Identify patients areas of responsibility in attending to care needs	96	3	1
Involve relatives/carers in planning care	51	47	2
Evaluate progress	86	12	2
at regular stated intervals	70	26	4
Involve patient in the evaluation of progress	89	10	1
Involve relatives/carers in the evaluation of progress	56	39	5
Only involve relatives/carers in the assessment, planning and evaluation of care if patient agrees to their involvement	61	15	24
other please state			

Patient Three

MOBILITY

Please read through the aims of care for mobility for patient three, listed below. Please indicate by ticking the appropriate box whether you think that the aim is "necessary" or "not necessary" for nursing the patient described.

Ensure the patient knows the location of:-

	Necessary %	Not necessary %	Don't Know %
bathroom	99	0	1
toilet	99	0	1
dayroom	99	0	1
ward kitchen	64	32	4
patient shop	98	1	1
patient snack bar	94	4	2
patient telephone	98	1	1

other please state

Patient Three

FEEDING

Please read through the aims of care for feeding for patient three, listed below. Please indicate by ticking the appropriate box whether you think that the aim is "necessary" or "not necessary" for nursing the patient described.

	Necessary %	Not necessary %	Do Kn
Enable patient to choose food desired	95	2	
Enable patient to eat at times of own choice	40	47	1
Provide a social environment at meal times	90	7	
Enable relative/carers to bring food into patient	70	26	
Identify patients current dietary habits	94	5	
Educate patient about a healthy diet	84	13	
Respect patients diet choices	95	2	
other please state			

Patient Three

DRESSING

Please read through the aims of care for dressing for patient three, listed below. Please indicate by ticking the appropriate box whether you think that the aim is "necessary" or "not necessary" for nursing the patient described.

	Necessary %	Not necessary %	Don't Know %
Enable patient to dress in own clothes	93	6	1
Or hospital clothes if desired	73	22	5
other please state			

Patient Three

CONTINENCE (URINE)

Please read through the aims of care for continence (urine) for patient three, listed below. Please indicate, by ticking the appropriate box, whether you think that the aim is "necessary" or "not necessary" for nursing the patient described.

	Necessary	Not Necessary	Don't Know
	%	%	%
Maintain dignity	94	5	1
Maintain privacy	95	4	1
Identify patients role in:-			
urine testing	88	11	1
urine collections	94	5	1
Maintaining a fluid chart	90	9	
other please state	-	-	1

Patient Three

CONTINENCE (FAECES)

Please read through the aims of care for continence (faeces) for patient three, listed below. Please indicate by ticking the appropriate box whether you think that the aim is "necessary" or "not necessary" for nursing the patient described.

	Necessary %	Not Necessary %	Don't Know %
Maintain dignity	94	5	1
Maintain privacy	95	4	1
Identify patients role in:-			
stool collection	94	5	1
maintaining a stool chart	90	9	1
other please state			

Patient Three

HYGIENE

Please read through the aims of care for hygiene for patient three, listed below. Please indicate by ticking the appropriate box whether you think that the aim is "necessary" or "not necessary" to nursing the patient described.

	Necessary	Not necessary	Don't Know
Enable patient to adhere to own:-	%	%	%
hygiene routine	98	1	1
standard	88	7	5
other please state			

Patient Three

COMMUNICATION

Please read through the aims of care for communication for patient three, listed below. Please indicate by ticking the appropriate box whether you think that the aim is "necessary" or "not necessary" for nursing the patient described.

	Necessary %	Not Necessary %	Do Kn
Reassure the patient	88	0	1
Inform the patient of:-			
medical plan	94	3	
diagnosis	81	9	1
progress	95	1	
investigations	96	0	
results	88	4	
likely outcome of care	94	1	
other please state			
Ensure understanding of the information given	95	0	
Co-ordinate information given	96	0	
Discuss nursing care plan with patient	90	4	
Enable the patient to:-			
express anxiety	97	0	
ask questions	97	0	
Reduce anxiety levels	97	0	
Give realistic information on the expected outcome of care	97	0	
other please state			

Patient Three

SOCIABILITY

Please read through the aims of care for sociability for patient three, listed below. Please indicate by ticking the appropriate box whether you think that the aim is "necessary" or "not necessary" for nursing the patient described.

	Necessary	Not necessary	Don Kno
	%	%	%
Provide stimulation	82	16	2
Provide divertional therapy	72	26	2
Reduce Isolation	85	12	3
Gain co-operation	94	4	2
Promote patient control over illness	90	6	4
other please state			

Patient Three

RELATIVES/CARERS

Please read through the aims of care for relatives/carers for patient two, listed below. Please indicate, by ticking the appropriate box, whether you think the aim is "necessary" or "not necessary" for nursing the patient described.

	Necessary %	Not Necessary %	Don't Know %
Reassure relatives/carers	96	1	3
Inform relatives/carers of:-			
diagnosis	71	23	6
progress	84	12	4
likely outcomes of care	82	14	4
investigations	81	14	5
results	77	16	6
medical plan	77	12	11
other please state			
Only give information to relatives/ carers if patient agrees	83	14	3
Do not give information to relatives/ carers unless asked	42	48	10
Give patient the responsibility of passing all information onto relatives/carers	45	46	9
other please state			

APPENDIX K

THE OBSERVED ALLOCATION OF NURSES TO GROUPS OF PATIENTS ON THE MEDICAL WARD

GROUP A

Observed Mix Of Nurses Allocated	No. of Times Mix Allocated
S/N (P/T) P/N C (2nd yr.) + P/N D (2ndyr.)	X 1
E/N C + ST/N 2 (3rd yr.) + AG/EN 6	X 2
S/N D (I/C) + P/N E (2nd yr.) + AG/SN F	X 1
S/N A (I/C) + ST/N 2 (3rd yr.) + P/N E	X 1
E/N C + AUX B	X 1
S/N A (I/C) + P/N D (2nd yr.)	X 1
E/N C + P/N D (2nd yr.) + AUX C	X 1
E/N B + ST/N 3 (3rd yr.) + AG/EN 3	X 1
S/N D + ST/N 3 (3rd yr.) + AG/SN H	X 1
S/N A (I/C) + AUX B	X 1
S/N A (I/C) + ST/N 2 (3rd yr.) + AUX A	X 1
E/N A + E/N C + ST/N 2 (3rd yr.)	X 1
E/N B + AUX B	X 1
S/N A + S/N B + E/N B + ST/N 2 (3rd yr.)	X 1
S/N (P/T) + ST/N 3 (3rd yr.) + AG/SN D	X 1
S/N D (I/C) + P/N C (2nd yr.)	X 1
S/N D (I/C) + ST/N 3 (3rd yr.) + P/N C (2nd yr.)	X 1
S/N D + ST/N 4 (1st yr.) + AUX B	X 1
S/N D + P/N B (2nd yr.)	X 1
ST/N 3 (3rd y.) + AUX B	X 1
AG/SN B + ST/N 3 (3rd yr.) + AUX B	X 1
E/N B + AG/EN 4	X 1
S/N C (I/C) + ST/N 1 (1st yr.) + AG/EN 2	X 1
E/N A + P/N A (2nd yr.) + ST/N 2 (3rd yr.)	X 1
SR> (I/C) + E/N A + ST/N 2 (3rd yr.)	X 1
S/N (P/T) + E/NC + ST/N 1 (1st yr.)	X 1
S/N A (I/C) + AG/SN A	X 1
SR. (I/C) + P/N A (2nd yr.) + P/N H (on loan from another ward)	X 1
S/N A (I/C) + P/N A (2nd yr.)	X 1
E/N C + AUX B	X 2
TOTAL	**32**

GROUP B

Observed Mix Of Nurses Allocated	No. Of Times Mix Allocated
SR. (I/C) + AUX A	X 3
S/N D (I/C) + AUX A	X 1
S/N D (I/C) + P/N D (2nd yr.) + AUX A	X 1
AG/EN 4 + ST/N 3 (3rd yr.)	X 1
S/N D (I/C) + ST/N 3 (3rd yr.) + AUX A + AG/SN G	X 1
E/N B + P/N D (2nd yr.)	X 1
S/N (P/T) + ST/N 2 (3rd yr.) + P/N E (2nd yr.)	X 1
S/N A (I/C) + P/N E (2nd yr.)	X 1
S/N C (I/C) + ST/N 1 (1st yr.) + AG/SN B	X 1
S/N (P/T) + ST/N 3 (3rd yr.) + AG/EN 1	X 1
E/N C + ST/N 3 (3rd yr.) + AG/SN D	X 1
S/N A (I/C) + ST/N 1 (1st yr.) + AUX C	X 1
S/N C + ST/N 2 (3rd yr.)	X 1
S/N C + ST/N 1 (1st yr.)	X 1
E/N C + ST/N 1 (1st yr.)	X 1
E/N C + ST/N 1 (1st yr.) + CT	X 1
E/N B + E/N C + ST/N 1 (1st yr.)	X 1
AG/EN 4 + AUX C	X 1
AG/EN 5 + ST/N 1 (1st yr.)	X 1
SR. (I/C) + ST/N 4 (1st yr.) + AG/SN D	X 1
SR. (I/C) + ST/N 4 (1st yr.) + AG/SN E	X 1
E/N A + AG/SN C	X 1
S/N A (I/C) + ST/N 3 (3rd yr.) + AUX A	X 1
P/N A + ST/N 3 (3rd yr.) + AUX A	X 1
S/N A (I/C) + AUX B	X 1
E/N B + AG/EN 1	X 1
E/N B + P/N B (2nd yr.)	X 2
S/N C + ST/N 3 (3rd yr.)	X 1
S/N C + ST/N 3 (3rd yr.) + ST/N 4 (1st yr.)	X 1
TOTAL	**32**

Nurses unallocated (floating) Sister x 5
Staff Nurse x 2

KEY (I/C) Senior nurse in group also In Charge of the ward
(P/T) Part time staff nurse worked 4pm to 9pm.
CT Clinical Teacher working with student nurse.
AG/SN Agency Staff Nurse
AG/EN Agency Enrolled Nurse

THE OBSERVED ALLOCATION OF NURSES TO GROUPS OF PATIENTS ON THE GYNAECOLOGY WARD

GROUP A

Observed Mix Of Nurse(s) Allocated	No. Of Times Mi Allocated
S/N A + ST/N B (3rd yr.)	X 1
E/N A + ST/N C (3rd yr.)	X 1
S/N *	X 2
E/N A + AG/EN 1	X 1
S/N A (I/C) + AUX A	X 1
E/N A	X 1
S/N B (BANK)	X 2
S/N B (I/C) + E/N A	X 1
S/N A	X 1
AG/SN 4 + AUX B	X 1
S/N A (I/C) + E/N A	X 1
AG/EN 5	X 2
S/N A (BANK) + AG/SN 4	X 1
AG/EN 2 + AG/EN 4	X 1
S/N A + ST/N D (3rd yr.)	X 2
S/N C (BANK)	X 4
AG/SN 1	X 1
S/N A (I/C) + ST/N D (3rd yr.)	X 1
ST/N D (3r yr.)	X 3
S/N A (I/C) + ST/N C (3rd yr.)	X 1
S/N A + E/N A	X 1
S/N C (BANK) + ST/N D (3rd yr.)	X 2
TOTAL	**32**

GROUP B

Observed Mix Of Nurse(s) Allocated	No. Of Times Mi Allocated
S/N B + ST/N E (3rd yr.) + AUX B	X 1
E/N C + AUX B	X 1
S/N * + AUX B	X 1
E/N B	X 3
AG/SN 2 + ST/N F (3rd yr.) + AUX B	X 1
ST/N B (3rd yr.)	X 1
S/N B (I/C) + AG/EN 3 + AUX B	X 1
S/N B (BANK) + AUX B	X 2
S/N B (BANK)	X 1
AG/EN 3	X 1
S/N B	X 1
ST/N F (3rd yr.)	X 2
ST/N F (3rd yr.) + AUX B	X 5
E/N B + S/N B (BANK)	X 1
E/N B + ST/N G (1st yr.)	X 1
E/N B + ST/N G (1st yr.) + AUX B	X 2
E/N A	X 1
ST/N F (3rd yr.) + ST/N G (1st yr.)	X 1
AG/SN 4	X 1
AG/SN 4 + ST/N G (1st yr.)	X 1
E/N B + AUX B	X 1
S/N B (BANK) + AG/SN 5	X 1
NO NURSES AVAILABLE GROUP SPLIT	X 1
TOTAL	**32**

GROUP C

Observed Mix Of Nurses(s) Allocated	No. Of Times Mi: Allocated
S/N A (I/C) + AUX A	X 1
S/N * + P/N A (2nd yr.) + Cover Group B	X 1
S/N C (I/C) + AG/EN 1	X 1
S/N C	X 1
S/N C (I/C)	X 2
S/N * + P/N A (2nd yr.)	X 1
S/N B (BANK) ST/N A (1st yr.)	X 1
S/N * + ST/N A (1st yr.)	X 4
E/N C	X 2
S/N C + ST/N A (1st yr.)	X 3
S/N * + AG/EN 5	X 1
E/N C (I/C) + P/N A (2nd yr.)	X 2
S/N C (I/C) + ST/N A (1st yr.)	X 1
E/N B + S/N C (BANK)	X 1
S/N * (I/C)	X 1
S/NC (I/C) + P/N A (2nd yr.)	X 1
AG/SN 4 + P/N A (2nd yr.)	X 1
S/N C (I/C) + E/N B	X 1
P/N A (2nd yr.) + ST/N A (1st yr.)	X 1
E/N C + ST/N A (1st yr.)	X 1
E/N C (I/C) + S/N * + ST/N A (1st yr.)	X 1
S/N C + AG/SN 3	X 1
E/N C (I/C) + S/N *	X 1
No nurses available - group split	X 1
TOTAL	32

KEY

(I/C)=+I
Charge c
ward

S/N * =
Agency s
on duty-
rosta.

THE OBSERVED ALLOCATION OF NURSES TO GROUPS OF PATIENTS ON THE GERIATRIC WARD

Mix of Nurse(s) Allocated	No. of times Mix Allocated	Mix of Nurse(s) Allocated	No. of times Mix Allocated
GROUP ONE		GROUP TWO	
E/NA	X 2	E/NA	X 1
E/NB	X 3	E/NB	X 1
S/NA	X 2	S/NA	X 3
S/NB	X 1	S/NB	X 1
P/NA (1st yr.)	X 2	P/NA (1st yr.)	X 2
ST/NA (3rd yr.)	X 1	AUXB	X 2
SR. + S/NB + AUX.B	X 1	S/NA + E/N B + AUX A	X 1
		AUXA + E/N (from another ward)	X 1
TOTAL	12		12
GROUP THREE		GROUP FOUR	
E/NA	X 1	E/NA	X 1
E/NB	X 1	E/ND	X 1
E/NC	X 1	S/NA	X 2
E/ND	X 2	S/NB	X 1
ST/NA (3rd yr.)	X 1	P/NA (1st yr.)	X 1
ST/NB (3rd yr.)	X 1	P/NB (1st yr.)	X 2
P/NB (1st yr.)	X 3	AUXB	X 2
AUXB	X 1	E/ND + AG/AUX A	X 1
E/ND + AG/AUX B	X 1	ALL NURSES TO COVER	X 1
TOTAL	12		12

NB. Patient allocation implemented on early shifts only on th geriatric ward. 12 early shifts observed. All three nurses o duty on the late shift covered the whole ward.

Nurses Unallocated (Floating) - Auxiliary X 5
AG/Aux. X 2
E/N X 2
AG/EN X 1

CLASSIFICATION OF GERIATRIC PATIENTS ACCORDING TO FUTURE PLANS FOR ACCOMODATION

Long Stay Geriatric Ward	19
Possible Long Stay Or Possible Transfer To Social Service Accomodation	7
On Waiting List For Social Service Accomodation	2
Not Yet Classified	6
Terminally Ill	1
TOTAL	35

Appendix M

Tables B, C and D indicate the number of permanent and transient nurses observed on each of the three research wards during the period of observation.

TABLE B ANALYSIS BY GRADE OF THE INDIVIDUAL NURSES OBSERVE TO WORK ON THE MEDICAL WARD FOR 32 SHIFTS OBSERVED		
PERMANENT STAFF	TRANSIENT STAFF	
1 Sister 5 Staff Nurses 3 Enrolled Nurses 3 Auxiliaries	4 Student Nurses (2 1st yr & 2 3rd 5 Pupil Nurses (2nd yr) 14 Agency Nurses 1 Nurse loaned from another ward	
Subtotal 12	Subtotal 24	TOTAL 36

TABLE C ANALYSIS BY GRADE OF THE INDIVIDUAL NURSES OBSERVED TO WORK ON THE GERIATRIC WARD FOR THE 19 SHIFTS OBSERVE		
PERMANENT STAFF	TRANSIENT STAFF	
1 Sister 2 Staff nurses 3 Enrolled nurses 2 Auxiliary nurses	2 3rd year student nurses 2 1st year pupil nurses 1 Agency Enrolled nurse working full time on the ward (temporary appointment). 7 Agency nurses 1 Bank nurse 1 Enrolled nurse loaned from another ward.	
Subtotal 8	Subtotal 14	Total 22

TABLE D ANALYSIS BY GRADE OF THE INDIVIDUAL NURSES OBSERVED TO WORK ON THE GYNAECOLOGY WARD FOR 32 SHIFTS OBSERVED

PERMANENT STAFF	TRANSIENT STAFF	
1 Sister 3 Staff Nurses 3 Enrolled Nurses 2 Auxiliaries	5 3rd year Student Nurses, 2 1st year Student Nurses, 1 2nd year Pupil Nurse, 1 Agency staff nurse working full time on the ward (temporar appointment 3 Bank Staff Nurses, 5 Agency Staff Nurses, 5 Agency Enrolled Nurses.	
Subtotal 9	Subtotal 22	Total 31

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The functioning of nursing routines in the management of a transient workforce

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The functioning of nursing routines in the management of a transient workforce

Project 2000 recommends supernumerary status for learner nurses. This recommendation is derived, in part, from research into the educational effects of the current organization of nurse training. However, little research appears to have been undertaken into how the current training programme influences the organization and implementation of patient care. The research from which this paper is taken, addresses this question. It demonstrates that the allocation of learners to wards gives rise to an unstable and transient workforce. Currently, ward sisters and charge nurses are expected to plan and be accountable for care given. This research suggests that nursing routines provide qualified nurses with a method for maintaining control, stability and accountability for the care given by an unqualified and everchanging workforce. It is suggested, therefore, that the promotion of individualized care in nursing requires a reduction in dependence on the transient workforce which results from including learners in the staffing establishment of hospital wards.

NURSING WORK

The last 10 years has seen an increasing focus on areas of nursing work originally classified by Barr (1967) as basic nursing care. Research into areas such as nutrition (Jones 1975, Hamilton-Smith 1972), urinary and faecal incontinence (Norton 1986), constipation (Wright 1974), and the prevention of pressure sores (Norton *et al.* 1975, David *et al.* 1983), all highlight the contribution basic nursing care makes to both the rate and extent of patient recovery. However, this research also suggests that basic care is frequently given in a routinized manner which impedes recovery. Attempts by the profession to improve standards of basic care include the introduction of the nursing process and systems of patient allocation. Dickinson (1982) suggests that these developments can be seen as a professionalizing strategy which redefines basic care as a 'problem-orientated, patient centred activity requiring considerable expertise and scientific knowledge. It thus provides for qualified nurses a means of recovering the only territory they can claim as their own'.

Attempts by the leaders of nursing to delineate an area of specialized knowledge and claim it as their own reflect a desire for nursing to acquire the traits which characterize an occupation as a profession. The functionalist analysis which underlies the trait theory of professionalization has recently been the subject of much criticism (Schrock 1987, Strong 1979, Davies 1983), which highlights the negotiated nature of professional power, and its location within a network of social and economic relations. Consequently Dingwall (1983) has highlighted the need for research into problems associated with the utilization and organization of specialized knowledge in society and the subsequent division of labour this generates.

Research by Melia (1987) suggests that in nursing, unlike many other occupations which claim professional status,

registration is not a prerequisite to practice, but a prerequisite to manage the implementation of practice by others who lack the knowledge or authority to make decisions about care themselves. This suggests that nursing is attempting to acquire the traits associated with professionalization while maintaining dependence on a division of labour which relies on an unqualified workforce to implement care.

Nursing process

The introduction of the nursing process and systems of patient allocation represents an attempt to organize nursing to promote the professional–client relationship which characterizes professional work, rather than the model of the assembly line associated with task allocation (Hegyvary 1982). However, the introduction of the professional model would appear to generate problems for sisters and charge nurses in terms of how to identify groups of patients whose total care can be allocated to unqualified nurses, and how to control the standards by which these nurses implement care, given that unqualified nurses lack the knowledge and professional authority to determine standards for themselves. While there has been considerable research which highlights the detrimental effects of the worker role on the education of learner nurses (Fretwell 1982, Orton 1981, Reid 1983), there has been very little research into the effects on patient care produced by service dependence on a learner nurse workforce. This research addresses this problem. The aim of the research was to identify how dependence on a learner nurse workforce influences the organization and implementation of patient care.

METHODOLOGY

Considerable research effort has been put into the development of objective descriptions of nursing work. For instance, the Scottish North-Eastern Hospital Board (1969), Goldstone *et al.* (1983) and Jelinek *et al.* (1974) have all attempted to produce objective measures of nursing work. While the tools produced meet management demands for staffing formulas to plan services, and monitor the quality of care, they tend to reify nursing practice and to produce a description of nursing which may not be shared by the nurses themselves. Therefore, these tools are not very useful in explaining nursing behaviour.

Qualitative research rejects attempts to produce objective description of social phenomena, as it recognizes that social phenomena are constructed from the meaning and understanding that individuals bring to the social situation and that this will determine the behaviour adopted (Field & Morse 1985). This suggests therefore that an analysis of the organization and process of implementing nursing care requires an understanding of how learners and other nurses define and interpret nursing, as this will determine their nursing behaviour. Consequently, a qualitative approach to data collection was adopted.

The data were collected on three wards, a 22-bedded gynaecology ward, a 28-bedded acute medical ward, and a 36-bedded long-stay geriatric ward. The wards selected were all nurse training wards reflecting three different clinical environments. All the wards were located in one District Health Authority to facilitate a contextual analysis which is central to qualitative research.

The introduction of the nursing process is part of a wider movement in nursing, which aims to incorporate social as well as medical definitions of health into nursing. For instance, Henderson (1966) identified the promotion of independence as the unique contribution made by nurses to patient care. While Bower & Bevis (1979) base their nursing model on Maslow's concept of self-actualization. It was recognized that, in practice, concepts such as independence and self-actualization have frequently proved difficult to implement, and therefore may not be observed. However, failure to observe changes in practice may not mean that the nurses are themselves unaware of the need for change. It was necessary, therefore, to develop a method for investigating the influence of developments in the academic orientation of nursing on the care given by practising nurses. Semi-structured observation schedules were developed for observing and recording the care given to individual patients. These schedules reflected changes in the academic orientation of nursing and were used during observation to promote discussion with the nurses about the care they gave in the context of the changes identified.

The schedules were derived using a modified delphi survey (Linstone & Turoff 1975) of 113 ward sisters/charge nurses working in 21 different clinical specialities in 14 health districts. The aim of the survey was to develop a professional definition of contemporary nursing practice, from practitioners who, because of their position in nursing, could be described as experts. This was to avoid the development of schedules from academic literature which, while theoretically sound, might not reflect current practice. The aim of the research was not to test academic theories in the practical environment, which assumes academic theories have an objective reality and can be seen to be applied. Rather the research aimed to understand the nurses interpretation of changes in nursing philosophy and how this influenced the care they gave.

Table 1 The allocation of learners to three nurse training wards

Ward	Gynaecology	Medical	Geriatric
No. weeks analysed	60	40	54
Total no. learners allocated	35	29	44
Average length of stay (wk)	8·8	8·5	5
Minimum length of stay (wk)	2	2	4
Maximum length of stay (wk)	23	14	6
Maximum period of staff stability (wk)	5 × 1	4 × 2	3 × 3
No. of weeks staff changed on ward	42	31	46

The survey

The survey consisted of a description of three different patients, of high, medium and low dependency. The description emphasized the patients' physical, psychological and social characteristics; no diagnosis was given. Therefore, the participants responded only to the nursing needs of the patient and not to the curative needs. The respondents were asked to give an open-ended description of the care needs of the patients described and an explanation for the care identified. A content analysis of the results was undertaken which formed the basis of the second round. A high degree of consensus was achieved on the second round of the survey for most aspects of care. The aims of nursing identified in the survey included physical rehabilitation of patients, the promotion of patient autonomy, and giving patients control over the care given. Aims such as these indicated that sisters/charge nurses were aware of changes in nursing philosophy, and felt that these should be implemented in practice. Their responses provided the schedules used to observe care on the three research wards.

THE STAFFING STRUCTURE ON THE RESEARCH WARDS

An analysis was undertaken of the off-duty rostas on each ward for approximately 1 year prior to the observation period, as it was recognized that the allocation of learners to wards provides the staffing context within which care is given. The number of weeks analysed on each ward's duty rosta totalled 60 weeks for the gynaecology ward, 40 weeks for the medical ward and 54 weeks for the geriatric ward. This was dictated primarily by the availability of sequential back copies of the duty rostas for each of the wards concerned.

Tables 1 and 2 give a breakdown of the analysis of the off-duty rostas on each of the three wards. Table 1 indicates that each ward gained or lost one or more learner nurses on average once a fortnight. Learners accounted for 40% of the funded staffing establishment on the gynaecology ward, 44% on the medical ward and 31% on the geriatric ward. This indicates that on each ward the sisters experienced a rapid turnover of a third and in some cases nearly half their staff.

Table 2 highlights the fluctuations in staffing levels which result from the allocation process. It indicates that for up to 65% of the time the wards were under the agreed staffing levels due to an under-allocation of learners. Observation, over a period of 2–3 months on each of these wards indicated that a shortfall in the allocation of learners to the wards was invariably supplemented by the use of bank or agency staff.

Table 3 gives the number of bank and agency nurses observed working on each ward for a temporary period of one or two shifts. It demonstrates that on over half the shifts observed agency and bank nurses were used. These nurses were not employed to help with an increased workload, as measurements of workload were not calculated by the staff on the wards, rather there was an agreed and relatively fixed minimum number of staff identified for the early and late shifts. The bank and agency staff were employed to bring the numbers up to this fixed minimum level on each of the shifts concerned. In each case the shortfall in available staff on the wards was generated by an under-allocation of learners to the ward for that week.

The analysis of the off-duty rostas highlights the very volatile staffing structure which this training system has generated. This provides the staffing resources within which sisters and charge nurses have to organize the implementation of care. In order to identify how this staffing structure influenced the implementation of care, it was necessary to undertake direct observation of the care given to patients. Observation, for a period of one complete shift, of the care given to 42 different patients in three different dependency categories was undertaken on the wards described above.

Patients' dependency levels

The dependency levels of the patients were derived using the progressive scoring assessment of capacity to cop-

Table 2 Fluctuations in the allocation of learner nurses in three wards

Number of learners	Gynaecology	Medical	Geriatric
Total no. weeks	60	40	54
1 Under allocation	11	12	10
2 Under allocation	14	3	8
3 Under allocation	3	7	2
4 Under allocation	—	3	—
5 Under allocation	—	1	—
Total under allocation	28 (47%)	26 (65%)	20 (38%)
1 Over allocation	4	5	6
2 Over allocation	8	1	3
3 Over allocation	4	2	—
4 Over allocation	1	2	—
5 Over allocation	2	—	—
Total over allocation	19 (31%)	10 (25%)	9 (17%)
Agreed level allocated	13 (22%)	4 (10%)	25 (47%)

% do not = 100% as rounded up.

Table 3 Shifts observed employing bank and agency staff

Ward	No. of shifts observed	Agency* nurses	Bank* nurses	Total
Gynaecology	32	18	7	25
Geriatric	20	7	1	8
Medical	32	21	0	21
Total	84	46	8	54

*Agency and bank nurses employed on the ward for one or two shifts at a time only.

with daily living activities developed by Hunt (1982). This is comprised of key components derived from the work of Norton *et al.* (1975) and Rhys-Hearn (1977). It was selected because it had been tested and found to have face validity by hospital and community nurses. A recent review of dependency schedules by the South East Thames Regional Health Authority (1987) suggests that effective completion of schedules by practitioners requires that these schedules are meaningful to the nurses, as well as managers and researchers.

The data were collected on each of the patients in the form of a case study. Mitchell (1983) defines a case study as 'the documentation of some particular phenomenon or set of events which has been assembled with the explicit view of drawing theoretical conclusions from it'. The care received by each patient for the entire shift was documented on the observation schedules derived from the survey. The aims of care identified in the schedules, were shared with the nurses who were asked to comment on these aims in the context of the needs of the patient being observed. The nurses' comments were also recorded.

The data were analysed using the method of analytical induction described by Silverman (1985) which can be applied to data collected in the form of case studies. In analytical induction, propositions about the data are derived, and the data are then searched for instances that falsify the propositions. If found, the proposition is redefined, or the case is excluded and the application of the proposition narrowed. Analytical induction therefore provides a method of testing the validity of theoretical explanations derived from qualitative data.

Meeting the patient's need for hygiene care

Research has indicated that learners are mainly responsible for implementing 'basic' care (Moores & Moult 1979, Fretwell 1982, Reid 1983). Consequently, this research focused on the organization and implementation of 'basic' care on each of the three wards. For the purposes of this article the way in which nurses responded to the hygiene needs of patients will be used as a case study and analysed using the technique of analytical induction.

The literature on the nursing process suggests that individualized care can be given by unqualified nurses so long as they adhere to a care plan. In a discussion of this problem Duberley (1979) suggests that under a system of patient allocation, a junior learner nurse may be responsible for implementing care planned by a qualified nurse, but may lack the knowledge to plan the care herself. This arrangement is also suggested by McFarlane & Castledine (1982). The literature therefore implies that individualized care can

Table 4 The number of qualified nurses working permanently on each research ward

	Gynaecology		Medical		Geriatric	
Post held	Funded	In post	Funded	In post	Funded	In post
Sister	1	1	1	1	2·18	1
Staff nurse	3	3	4	3	2	1·66
Enrolled nurse	3	3	2·5	3	4	4

be introduced while still depending on a transient and largely unqualified workforce.

This literature gives rise to the first research proposition — that qualified staff identify the care needs of patients, but delegate this work to the unqualified learners and auxiliaries to implement.

All three wards were attempting to implement individualized problem-orientated approaches to nursing. One would, therefore, expect to observe written and oral instructions being given to learner nurses regarding the hygiene needs of specific patients. In fact, of the 42 patients observed, only five specific instructions relating to hygiene needs of patients were observed.

The lack of formal instructions negates the first proposition. It raises the question of how the transient staff, many of whom are unqualified learners, know what to do, and suggests instead the second proposition — that the absence of formal instructions and the philosophy of individualized care should give rise to the observation of differences in the way nurses interpreted and met the hygiene needs of patients in similar dependency categories. This proposition is substantiated by the nurses' views on the aims of nursing care. On all three wards, nurses, both learner and qualified, when questioned, recognized and supported the therapeutic aim of rehabilitation, patient control over the course of their illness and care and patient autonomy identified as appropriate goals of care in the survey.

Observation, however, revealed that the patients' hygiene needs were met in a standardized manner. The therapeutic aims identified were not selectively applied according to individual patient goals, rather they had become an inherent part of the routine. Table 4 gives the number of qualified staff available within which the supervision of learners was organized on each ward.

ORGANIZATION OF CARE ON THE MEDICAL AND GYNAECOLOGY WARDS

Both of these wards had introduced systems of patient allocation. However, the constraints of the off-duty and the transient throughput of nurses meant the extent to which team nursing could be achieved on either ward was limited. On the gynaecology ward the nurses were divided into three teams. A total of 96 team allocations were observed during the period of research. On only 26 occasions were the teams headed by the staff nurse or enrolled nurse attached to that team. On the other 70 occasions the teams were headed by a bank or agency nurse, a learner nurse, or the staff or enrolled nurse of that team was also running the ward or covering more than one team.

In order to reduce this problem the medical ward had two teams. On this ward a total of 64 teams were observed. Here 33 of the 64 teams observed were headed by the staff or enrolled nurse allocated to that team. The remaining teams were subject to the same variety of leadership arrangements identified on the gynaecology ward. Given this instability in the composition of teams of nurses, how was care organized?

On the medical ward all patients needing assistance with hygiene were given a bowl and left to manage. After a short while the nurse would return to the patient; if they had been unable to manage, assistance would be given. Active rehabilitation was interpreted as giving the patient the opportunity to wash independently, followed by giving any assistance required. No differentiation was made between patients requiring rehabilitation and those immobilized for therapeutic reasons.

On the gynaecology ward all patients were given a bath following the removal of wound drains and urinary catheters, regardless of the patients' underlying level of fitness. The therapeutic aim of early mobilization following surgery had been interpreted by the nurses as giving the patient a bath, and incorporated into the routine of care.

Observation therefore suggested that the patients' hygiene needs were met in a standardized manner. The therapeutic aims identified by the nurses were not selectively applied according to individual patient goals, rather they had become an inherent part of the routine. This suggests that the transient staff, on whom the ward depends to implement much of the care required by

patients, learn what to do by learning the ward routine. This gives rise to the third research proposition — that it is this routine, and not the written or oral instructions given by qualified staff, which sets the agenda for the nursing care given on a ward. However, this analysis suggests that qualified staff could identify individualized care needs of patients and instruct learners to give care differently. It therefore implies a failure on the part of the qualified staff to do this. There was, however, evidence to suggest that qualified staff themselves conformed to the routine when implementing 'basic' care.

On two occasions the staff nurse on the medical ward specified at the morning report that the patient under observation should be given a blanket bath and then sat out in a chair, and not simply given a bowl. On both occasions the patient was actually given a bowl and left to manage according to the routine described above. In one of the cases it was the staff nurse herself who gave the patient the bowl and left him to wash himself. It appears therefore that the routine dominates the nursing agenda, not only for the transient staff passing through the ward but also for the qualified staff working on the ward.

Even if attempts are made to individualize care, dependence on unqualified and/or transient staff undermined this. On one occasion on the gynaecology ward a staff nurse was observed to offer a patient a positive choice between a bath or a wash following the removal of her wound drain and urinary catheter. This aspect of care was then delegated by the staff nurse to an auxiliary. The staff nurse did not mention that she had offered the patient a choice in this aspect of care. The auxiliary approached the patient telling her her bath was ready. The patient complied and the element of choice initiated by the staff nurse was lost.

These two case studies suggest that the formal identification of individual care needs by qualified staff does not necessarily result in individualized care. During the process of implementation the instructions are reinterpreted to conform to the normal pattern of care on the ward. It would appear therefore that the assumption prevalent in much of the literature on the nursing process, that qualified staff control the nursing care agenda on the ward, is in fact open to question. The data collected in this research suggest that the nursing agenda is set not by the qualified staff, but by the transient nurses working on the ward. The transient nurses use the ward routine and not the instructions of qualified nurses to identify the care needs of patients. This is accepted by the qualified staff as it enables quick and efficient utilization of a transient workforce. This final proposition is substantiated by the organization of care on the geriatric ward.

ORGANIZATION OF CARE ON THE GERIATRIC WARD

On this ward at the start of an early shift, 07.30, 23 of the 36 patients were likely to have been incontinent of urine and to be lying in a wet bed. Some of them would have been attended to by the night staff. The morning care assumed five nurses on duty at 07.30 — one qualified nurse, either an enrolled nurse or a registered nurse, one nursing auxiliary and three transient nurses, either learners or bank and agency staff. The patients were divided up into four groups of nine patients each. Each group was allocated a nurse who was responsible for ensuring all nine patients were up, washed, sat on the commode and dressed for breakfast. The fifth nurse, usually the auxiliary, floated and gave help with lifting.

The pace at which this work was completed left little time for physical rehabilitation of these patients or reorientation of those that were confused. The nurses themselves acknowledged the importance of these aims of care when discussing alternative care strategies derived from the survey. The nurses recognized discrepancies between the goals of individualized care that they themselves supported and the care they actually gave. What they were not able to do was to identify how they could fit these aims of care into their nursing schedule.

The problem identified by the nurses was that if they took the time necessary to incorporate rehabilitation into the care they gave, some patients would be left sitting in a wet bed when breakfast was served at 08.30.

While it is possible to suggest that breakfast could be served over a longer period of time to reduce the pressure on the nurses, this does not overcome the problem of which patients to get up and which to leave, as most of the patients were either lying in a wet bed or in urgent need of the commode. The central problem was not located in providing individualized care for one patient, but in organizing the implementation of care by one nurse to meet the individual needs of nine patients. Staggering the serving of breakfast may facilitate rehabilitation for some patients but may result in the remaining patients being left for a much longer period of time before any care was given. The problem confronting the nurses was one of prioritizing between the care needs of nine different patients.

This problem was realized by the nurse in charge of the ward who had to ensure that a minimally acceptable standard of care was given by transient staff, who frequently she had not worked with before. Patients who had been allocated to the care of transient staff who did not know them, if still in bed when given breakfast, might well be in a wet bed, or in urgent need of the commode. In order to be

satisfied that none of the patients in the other three groups having breakfast was still sitting in a wet bed, the nurse in charge needed to be able to see quickly and easily that a minimum standard of care had been given. She had to be able to make this assessment while at the same time attending to the needs of her own nine patients. If the patients in the other three groups were up and dressed when given breakfast the nurse in charge could assume that they were at least dry and had used the commode, and therefore a minimally acceptable standard of care had been achieved. While this method ensured that the nurse in charge could ascertain that a minimally acceptable standard of care was achieved on the ward, it reduced the opportunity for patients to be given a choice about whether or not they got up and dressed before breakfast. Giving the patients a choice would mean delegating decisions to transient staff whose abilities were not known by the nurse in charge.

The case study of hygiene care on the geriatric ward identifies that in implementing care to a number of patients nurses are faced with the need to prioritize the organization of care between patients. The need for decisions about priorities is not always apparent when care is planned on an individualized basis. Hunter (1980) suggests that the National Health Service is dominated by a rational management model which assumes the goals of health care can be clearly identified and appropriate management structures introduced to ensure those goals are met. This research, as does Hunter's, highlights the problematic nature of the assumptions on which the rational model is based. It suggests instead the existence of conflicts between nursing goals and organizational goals. Ward dependence on a transient workforce meets educational and manpower demands within the health service but gives rise to a staffing structure which acts as a constraint on the implementation of individualized care.

Sharkansky (1972) recognized that within any organization there will be differing views as to what the overall goals of the organization are. Some of these interpretations will conflict. As a result different sub-sections of the organization will adopt strategies which conflict with the goals of another sub-section, or even with their own goals. He suggested that part of the problem arises out of the difficulty of producing incontrovertible evidence that one set of goals or strategies provides the best way to solve a given problem. This research suggests that the aims of care identified by the ward sisters/charge nurses in the survey, while reflecting changes in the orientation of nursing practice, are frequently in conflict. For instance, the aim of promoting patient choice and autonomy can conflict with the aim of therapeutic rehabilitation. A patient may, as some were observed to do, choose dependency.

Given this ambiguity about goals and strategies Sharkansky was concerned to identify the processes by which strategies came to be selected for implementation from the vast number of potential strategies. He identified that most organizations evolve decision rules which, he suggests, provide a framework for decision making in the organization. Among the decision rules he identified was the use of routines to govern decision making. He defines routines as the 'decision rules that specify which of the numerous inputs that might be relevant are actually considered in making decisions ... they enable the decision maker to select ... those few considerations to be kept in mind from among the myriad that are potentially relevant' (Sharkansky 1972).

Contradictions in nursing goals

The above case studies highlight inherent contradictions in the goals of nursing care, for instance between promoting individualized care and monitoring the care given by transient, and therefore relatively unknown, staff. This situation is exacerbated by the need for one nurse, who does not know the patients very well, and who frequently may not be qualified, having to prioritize the implementation of care to several patients, with minimum supervision available.

Sharkansky's work suggests that nursing routines provide a framework for resolving ambiguities and conflicts inherent in nursing work, though rarely acknowledged in practice. It is suggested that decisions about prioritizing and organizing care are taken with reference to the routine. Moreover, that reference to the routine is more important in determining how care is implemented than the formal instructions given by qualified staff. The routines are used by the transient workforce as a quick and effective method of identifying the work requirements on a ward. This is sanctioned by the qualified staff as it provides a quick and efficient method of utilizing the transient staff, on whom they depend to implement care, and of subsequently monitoring the care given by these staff to ensure a minimally acceptable standard of care is given.

DISCUSSION

The introduction of individualized care suggests that patients in a similar dependency category on the same ward could have very different nursing care needs. Meeting the individualized care needs of patients implies developing innovative approaches to care. The more innovative the care the more likely it is to differ from the care given on other wards in the hospital, or even to other patients on the ward

If the care differs too much from ward to ward or patient to patient, then the extent to which transient staff can be fully employed on a ward without intensive reorientation is substantially reduced.

As the analysis of the staffing structure indicates, opportunities for reorientation are limited given the high throughput of transient staff, and the substantial contribution they currently make to care. The quick and effective utilization of transient staff requires those staff to be able to recognize quickly, and with minimum instruction, the care needs of patients on the ward. This is greatly facilitated if the care given on the ward is similar to care given on other wards in the hospital, i.e. if it conforms to a routine. This research suggests that sisters and charge nurses accept the use of routines to determine nursing work as they are dependent on a transient workforce to implement much of the care on the ward.

This situation is reinforced by the need for accountability in nursing practice. The location of accountability for nursing practice in this country is extremely vague. Increasingly, accountability for nursing care is being located with the sister or charge nurse on the ward (RCN 1980). The accountability of senior nurse managers for clinical nursing practice has never been clearly identified.

The problem confronting nurses attempting to introduce individualized care, identified in this research, is one of prioritizing between the care needs of several patients when organizing the implementation of care. This problem is not resolved in individual care plans. It requires the nurses giving care to prioritize between the needs of different patients during the course of implementing care. Sisters and charge nurses have no control over the selection of a large proportion of the nurses employed on their wards. Many of these nurses are not yet qualified. Should the transient nurses allocated to their wards change the care planned in the course of prioritizing between the needs of different patients the sister or charge nurse cannot be held accountable, as they did not authorize the change. Instead the nurse determining the priority would be accountable (Batey & Lewis 1982). However, it is questionable whether learners or transient staff have the authority or knowledge about the patient required to determine priorities, or to be held accountable for the consequences, such as leaving one patient in bed for a prolonged period of time in order to give rehabilitative care to another patient.

Decision-making process

Recently it has been suggested that individualized care would be enhanced if learner nurses were given greater opportunities to participate in the decision making process on the ward (Pembrey 1980). Fretwell (1982) has suggested that this would enhance the educational opportunities available to learners on a ward. Both stress the need for learners to take decisions in consultation with qualified staff. However, Runciman (1983) found approximately three-quarters of the ward sister's activities last less than 2 minutes, and half less than 1 minute. This fragmentation was created by the numerous interruptions to which she was subject, and the high level of sensory perception she had to develop in order to co-ordinate activities on the ward. It is difficult to see how, in this climate, a sister or charge nurse can be expected to initiate further interruptions by encouraging learners to become more involved in the decision making process.

If, on the other hand, transient nurses allocated to the ward adhere to a ward routine when ordering priorities on the ward, a routine that is known to, and agreed by, the sister or charge nurse, then the sister or charge nurse can accept accountability for the care given by transient nurses allocated to their ward. As the case study on the geriatric ward indicates, adherence to the routine enables the nurse in charge to ascertain that a minimum acceptable standard of care has been achieved, whereas delegation of decision making to unknown staff does not. Learners, in deciding to adhere to the routine when giving care, lessen the extent to which they can be held accountable for the care they give in an unfamiliar environment.

The current organization of nursing work at ward level does not promote a utilization of nursing knowledge by qualified nurses to resolve the dilemmas and ambiguities inherent in patient care identified in this research. Instead, qualified nurses, who potentially have the knowledge and authority required to change practice are removed from a confrontation of these problems by their role as managers of transient nurses to whom the task of implementation is delegated. Moreover, as Melia (1984) found, the current educational socialization of student nurses gives rise to transience or 'moving on' as a learned method of dealing with work problems, as Melia suggests this provides an explanation as to why so many qualified nurses undertake a series of JCNB (now ENB) courses (Rodgers 1983).

The above findings suggest that the management of manpower planning by identifying the number of nurses required on a ward, rather than the people required on a ward, serves to reinforce a lack of commitment to professional practice by perpetuating adherence to hospital routines and by stifling initiatives for changed and improved practice. Moreover, the need to manage by numbers results from fluctuations in staffing levels on training wards brought about as a direct consequence of the allocation of learners to those wards. Finally, if manpower

systems which allocate bank or agency nurses to wards for half shifts to cover measured fluctuations in workload, are introduced, then even if learners acquire supernumerary status, as proposed in Project 2000 (UKCC 1986), the problem of transience will be perpetuated.

Conclusion

If as a profession, nursing wishes to reduce dependence on ward routines as a method of organizing care, and so reduce the iatrogenic consequences identified as resulting from these routines, then it appears necessary to reduce dependence on the transient workforce which results from including learner nurses in the staffing establishment of training wards. It is not suggested that a stable workforce will of itself produce the changes in practice identified as necessary by the profession. What is suggested is that it will provide an environment that is conducive to the types of changes required. One in which nurses interested and motivated to improve their practice by developing innovative approaches to care will not be continuously undermined and hampered by their dependence on a transient and largely unqualified workforce.

Research into nurse education (Melia 1987, Fretwell 1982) has highlighted the detrimental effects service demands have on the education of learners. This research highlights the problems generated for service by the educationalists' demands for clinical experience for learner nurses. The effects on service, though difficult to quantify, should be considered in any debate about the costs of implementing the recommendations put forward in Project 2000.

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